SASKATOON DISTRICT HEALTH

HEALTH RECORD DOCUMENTATION STANDARDS

Appendix A
For Former Saskatoon District Health Sites and Affiliates

Saskatoon Health Region

Saskatoon, Saskatchewan

May 2003

Appendix A

TABLE OF CONTENTS

Part 1 GENERAL CHARACTERISTICS

A health record shall be maintained for each individual who receives health care services within the programs of Saskatoon Health Region. All significant clinical information is incorporated in the health record. The health record is available to clinicians for continuing care.

The purposes of the health record are as follows:

1. To serve as a basis for planning patient/client/resident care and for continuity in the evaluation of the patient/client/resident's condition and treatment;

2. To furnish documentary evidence of the course of the patient/client/resident's evaluation, care, treatment, and/ or change in condition;

3. To document communication between the clinician responsible for the patient/client/resident and any other clinician who contributes to the patient/client/resident's care/ treatment;

4. To assist in protecting the legal interest of the patient/client/resident, the organization, and the clinician responsible for the patient/client/resident; and

5. To provide data for use in continuing education and research.

The principles of the health record documentation are related to:

- Quality health care services;
- Effective communication;
- Continuity of care across the health delivery system;
- Meeting legal, professional and organizational requirements;
- Accountability; and
- Quality improvement and research support.

Part 2 GENERAL DOCUMENTATION STANDARDS

In general, the health record is:

Confidential

- The health record information is protected from unauthorized access, loss and damage. Charts are to be stored in a designated location that protects privacy but allows authorized access.

- The information is pertinent to the individual receiving the health care service. Third party references should only be documented when crucial to the care of the individual; in such cases, the person should be identified by relationship only, not by name. Information about another person's health status must be severed upon disclosure unless consent is obtained.

Contemporaneous

- Frequency of charting is dependent upon intensity of service requirements, discipline-specific standards and guidelines, and any applicable policies and/or standards of the program or service.

- A written entry must NOT be altered, added or edited on a previous visit's record once all relevant information has been compiled for that visit (i.e. the chart is considered to be a completed record according to health record staff). Alterations or additions to the record must NEVER be made after the chart has been copied for a legal investigation, after a subsequent adverse result has occurred, or after a complaint has been filed.

- In cases of unusual occurrences, the documentation must be made at the time of the event. The person making the entry must have direct personal knowledge of the information being recorded.

Chronological

- Ideally, documentation should be entered in chronological order.

- In cases where a late note must be written, the writer will note the date and time of the entry with 'Late Entry' written beside the date and time. No gaps or lines will be left between entries. It is not acceptable to insert an entry between two previous entries.

Complete & Accurate

- All pages of the health record must be labeled with the minimum identifiers of the patient's/client's/resident's/ name, HSN and date of birth. This ensures that when the health record is photocopied or faxed, each page can be correctly correlated with the right patient/client/resident.

- Flow sheets are useful charting tools to eliminate repetitive charting of routine care. When flow sheets are used, tick boxes and check marks, abbreviations or care-provider's initials can be used to document routine assessments and care. Variations from normal assessment findings and/or expected outcomes, additional pertinent information, and special considerations (see page 8) must be documented in the Progress Notes.

- All entries into the health record must include:
  - the date (in day, month, and year format) and
  - time of entry (according to the 24-hour clock),
  - an identifiable signature
  - and the author's printed name and designation/ position.

- Initials are acceptable on various clinical forms if there is a corresponding signature record identifying the printed name, the initials and signature, and the professional category of the care provider kept on the unit or within the department.

Clear

- Documentation should clearly communicate the health status of the individual and result of health services delivered. The documentation should not lead to misinterpretation, misunderstanding or miscommunication by any member of the health care team or legal representatives.

- Documentation will be completed according to organization and department standards, guidelines, and policy. Use of jargon, unauthorized abbreviations, and unauthorized forms is not acceptable, nor is use of personal phrases or terms.

- Documentation should be streamlined to permit ease of use, reduction of duplication and proliferation of forms.

Factual and Objective

- Documentation should reflect a professional attitude toward the individual and the care/ treatment provided.

- Documentation should reflect facts and direct observations only. Secondary information, that is, information from other sources, can be recorded if the source has been identified. As much as possible, observations should be quantifiable, that is, numerical or measurable.

- It is not acceptable to chart inferences or assumptions without professional objectivity. Subjective opinion or subjective analysis must only be done with extreme care and attention and must be supported by facts.

- Neutral language should be used in documentation. Eliminate any bias or unsubstantiated judgement in the documentation.

Appropriate

- Documentation will be based on discipline-specific or department-specific guidelines or standards wherever applicable. Department Managers or Professional Leaders will be accountable for ensuring that appropriate documentation standards are developed for their area of health care service.

- Medical Affairs will be responsible for ensuring physician documentation standards are current.

- Charting by exception is an acceptable documentation practice in areas where standard protocols, clinical pathways, or programs have been developed and are routinely used. In situations where the protocol was not followed, the staff will document in the Progress Notes what care was provided instead of or in addition to the protocol.

- Documentation on the health record will be entered on approved forms and following organizational policies.

- Use of abbreviations on the health record is restricted to those approved by the organization. (Refer to the SHR Policy on *Approved List of Abbreviations and Symbols).* Abbreviations that have multiple interpretations should not be used, especially where confusion could be critical for care decisions.

- All health science students will follow the documentation standards of their discipline. Entries made by students must also indicate their student status.

Legible

- All entries will be made in ink (black ink preferred for ease of photocopying) and in legible handwriting where an electronic health record is not available. Appropriate English language writing mechanics, grammar and spelling are to be used.

- Where possible, key documents such as diagnostic/therapeutic reports, physician-related reports and medication lists will be transcribed or printed electronically.

- Errors are corrected by drawing a single line through the error with a signature and 'ERROR' clearly marked above the line. Correction fluid or black markers are not to be used. Do NOT obliterate the initial notation.

- Damaged or wet pages are not to be removed and are only recopied if illegible. The damaged page is maintained in the chart as a reference if it is possible to do so.

Special Considerations – Legal Guidelines

1. Chart Significant Legal and Medical Situations

Chart any situation that may have legal implications such as:

- Refusal or inability to give information.
- Non-compliance.
- Unauthorized items at bedside.
- Tampering with equipment.

Chart any situation that may have medical implications such as:

- Non-routine findings that do not fit on standard forms and flow sheets; any observation that needs further explanation.
- Changes in condition and actions taken in response.
- Contacts initiated regarding a change in a patient's/client's/resident's condition and whether the contact was successful.
- The patient's/client's/resident's response to treatment.
- Compliance to treatment program/care plan.

2. Chart Complete Assessment Data

This is based on specific documentation guidelines for the department and professional practice.

3. Document Discharge Instructions

Education of the patient/client/resident/client is part of the care delivery process. Documentation of the education provided to the patient/client/resident and the family should be included in the health record.

4. Physician Orders

In situations where verbal or telephone physician orders occur it is the responsibility of the physician to co-sign each order. The name and position of the writer must be documented.

5. Documentation of the following on the health record is NOT acceptable:

- Staffing problems or shortages.
- Staff conflicts.
- Words associated with error, such as 'accidentally', 'mistake', or 'I didn't mean to.'
- Casual conversations about the patient/client/resident to a supervisor/ manager. Only chart when this is a formal report.
- Incident reports. Do not chart that the report is completed, but do factually record the unusual occurrence on the appropriate form.

Part 3 *HEALTH RECORD FORMAT CONSIDERATIONS*

Organization of the Record

- The acute care health record in Saskatoon will be organized according to the accepted Chart Order for Saskatoon hospitals. (Refer to Part 6: Chart Order.)

- The health record in non-acute or rural agencies will be organized according to accepted chart (or file) order for the agency/facility.

- The completed health record will be organized according to the accepted historical chart order associated with the appropriate Health Record department.

Computer-based Record

- Any electronic versions of the health record will be kept in accordance with the *Guidelines for the Protection of Health Information (COACH, 2001).*

- Electronic versions of the health record will meet or enhance the written documentation standards.

- When appropriate, the electronic version of the health record may be deemed the original health record and be used as the legal reference. Strict adherence to technology protocols and ability to prove sustainability over the legally required retention period must be maintained.

Transitory Health Records

- Media, including digital and film records, are considered to be transitory or non-permanent records if not stored or available in the permanent health record. The legal record is considered to be the professional interpretation or findings from the media including digital and film records.

- Photocopied records from another site or location will only be kept in the permanent health records when:
  - additional documentation is added to the record;
  - indication is provided to keep the record; or
  - there are extenuating circumstances.

Forms Design

- In Saskatoon, the Clinical Forms Committee, a subcommittee of the Clinical Records Committee, approves all clinical record forms used for documentation. Format guidelines are established under organizational policies. (Refer to SHR Policy # 7311-20-002 in Part 7: Standards for Creation/ Revision of Clinical Health Record Forms.)

- White paper is the preferred choice for paper records due to its cost and ease of photocopying. Where required to assist with recognition and identification of key documents, professional disciplines can follow the colour guidelines for discipline or program -specific forms (Part 8: Colour Guidelines). Booklets are discouraged due to the difficulty in reviewing the content of the historical record file.

- Documentation should be streamlined, reducing the number of forms required and the amount of duplication for data documentation.

Use of the Record

- The health record should be used for communication among clinicians and support staff. Documentation guidelines and clinical forms used should consider both the ease of use by the care provider documenting on the record and the ease of understanding the content by other care providers.

- The health record is used as legal evidence of health care services delivered. Any loss or misuse must be reported to Health Records immediately.

- The health record can be used for research if authorized approval is received by the Research Services Unit (RSU) under Strategic Health Information & Planning Services (SHIPS). Appropriate documentation regarding the authorization of the research study should be available upon request. In order to determine if a project is research or quality assurance, the following criteria may be applied, as a general guide (Source: Jarvis, H. 2000. Health Care Management Forum, 13(4):34-36):

	Research	***Quality Measurement***
Purpose	Disciplined inquiry and establishment of facts	Determination of quality of service delivery
Generalizability	Generalizable knowledge	Only generalizes when variables are identical
Use of findings	Applications of knowledge in situations to improve outcomes	Change process to achieve performance
Subjects	Usually patients/ staff not already receiving intervention	Usually patients/ staff already involved in a program
Comparative	Usually use of control group	Use of benchmark or standards

***Ethical factors that must also be considered**:*

- *Does the project require ethical review and approval?*
- *Are patients/clients going to be contacted after their health records are reviewed? If the potential exists for patient/client contact, then ethical review is required, and the project is considered to be research.*
- *Will the data be de-identified?*
- *Is the data leaving SHR and being used externally by other individuals?*

Part 4 CONTENT OF THE HEALTH RECORD

COMPONENT	EXAMPLE OF ACUTE CARE RECORD
Assessment/ History	Assessment & Reassessment Medical History Physical Examination
Care Plans/ Outcomes	Physician Orders Clinical Pathways Care Plan/Treatment Plan Program Plan Protocols
Consults	Medical consultant reports Other program services Allied health professional services Community services
Progress Notes	Emergency Record Treatment Record Progress Notes Multi-disciplinary Progress Notes Anesthesia Documentation Operative Report
Flow sheets	Nursing Flow sheets Graphic Records Medication Administration Records Fluids and Transfusion Records Calorie Counts
Results	Diagnostics Reports Laboratory Reports Radiology Reports Nuclear Medicine Reports Hemo-dynamics reports Electro-diagnostic Reports Pulmonary Reports Pathology Report Autopsy Report
Summaries	Outcomes/ Results of service Physician Discharge Summary
Legal/Regulatory (Consents/ Release/ Transport)	Registration Record Consent Forms Advanced Care Directives Restraints

Part 5 FRAMEWORK FOR STANDARD DOCUMENTATION

1. NURSING

A. ASSESSMENT AND/OR ADMISSION

1. Responsibility

    1.1 Who is responsible for ensuring the recorded information is complete and accurate?

2. Completion Requirements

    2.1 Timing of the documentation
    2.2 Complete assessment will be documented in the admission sheet.

B. CARE PLANS

1. General

    1.1 Who should document?
    1.2 Frequency of documentation
    1.3 Verbal orders
    1.4 When a patient/client/resident is transferred
    1.5 Standard Orders are not in effect until signed by the most responsible physician. By drawing a line through a specific order and the clinician signing his/her initials, certain elements of a standard order set may be deleted.

2. Responsibility

    2.1 Who?
    2.2 Specific requirements
    2.3 Delegation e.g. students

C. PROGRESS NOTES

1. Responsibility
    1.1 Who.
    1.2 Students

2. Frequency
    2.1 Standard practice

3. Content

3.1 Response to treatment.
3.2 Acute changes in status.
3.3 Adverse reactions to treatment or drugs.
3.4 Fundamental decisions about ongoing treatment including medication, invasive procedures, consultations, treatment goals, decisions regarding resuscitation, supportive care only, etc.
3.5 Invasive procedures
3.6 Discharge plans
3.7 Documentation in the event of death, including the date and time of death.
3.8 Such other information as may be pertinent, such as temporary leaves, refusal of treatment.

2. ALLIED HEALTH PROFESSIONALS

1. CONSULTATION/ INTAKE

1.1 Responsibility

1.2 Identification

1.3 Timing

1.4 Content

2. ASSESSMENT/ INTERVENTION REPORT

2.1 Responsibility

2.2 Identification

2.3 Timing

2.4 Content

3. REVIEW/ PROGRESS NOTE

3.1 Responsibility

3.2 Identification

3.3 Frequency

3.4 Content

4. DISCHARGE/ DISCONTINUATION OF SERVICE SUMMARY

4.1 Responsibility

4.2 Identification

4.3 Timing

4.4 Content

3. CLINICAL PATHWAYS

A clinical pathway is a multidisciplinary clinical management tool that outlines and sequences best practice in the care and treatment of particular patient populations across the care continuum.

Documentation standards and a template of the clinical pathway form have been developed for the acute care setting in Saskatoon. Please contact the Clinical Pathways Coordinator for further information. (Refer to Part 9: Contacts for Discipline/ Department-Specific Standards)

Part 6 SASKATOON HOSPITALS CHART ORDER

The following is the Tab Order of the Chart for Saskatoon hospitals:

1) **Orders**: Included in this section are all physician orders, standard order sets, protocols, regimes and directives and the current pharmacy profile.

2) **Medication Administration Record (MAR)**: This section includes the medication administration record not kept in the nursing MAR binder. Also included are immunization or anti-coagulant records.

3) **History & Consults**: Included in this section is the physician history and physical, the nursing database, as well as consult reports from consultants, any professional disciplines and/or service programs

4) **Clinical Data**: This section includes all clinical measurements other than fluids such as critical care and specialty unit booklets, vital signs, clinical monitoring, diabetic records, neurological records, & growth & development.

5) **Fluid Balance**: This section includes In & Out calculations, IV therapies, transfusions and calorie counts.

6) **Progress Notes**: Narrative summary progress documentation by all disciplines involved in care, with the exception of nursing. Clinical Pathways booklet will be found in this section. At RUH, the need for a Resident progress note (pink) is accepted.

7) **Nursing Records**: All nursing related daily flow sheets, assessments, teaching, wound care and progress notes that do not fit in clinical data, fluid balance or progress notes sections.

8) **Laboratory Reports**: All laboratory reports including hematology, chemistry, microbiology and pathology.

9) **Diagnostic Reports**: All reports related to medical imaging, nuclear medicine, cardiology, pulmonary or neurological tests and procedures.

10) **Miscellaneous Records**: Includes all out-of-hospital forms, transfer records, Emergency records, intra-operative records and legal documents such as advanced care directives, consents, releases and authorizations.

Part 7 STANDARDS FOR CREATION/REVISION OF CLINICAL HEALTH RECORD FORMS – Acute & Other-than-Acute Care (refer to SHR Policy # 7311-20-002)

Part 8 COLOR GUIDELINES FOR DISCIPLINE OR PROGRAM SPECIFIC CLINICAL FORMS

Professional Group	Pre-inked stripe at bottom of the page	Professional Group	Colored Forms (whole page)
Speech Language Pathology	Blue stripe	Recreation Therapy	Yellow
Occupational Therapy	Green stripe	Physician progress notes	Pink
Physical Therapy	Red stripe		
Social Work	Blue & green stripe		
Clinical Nutrition	Orange stripes		

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Part 9 *DEPARTMENT CONTACTS*

LOCATION	*CONTACT*	*CONTACT NUMBER*
Acquired Brain Injury Outreach Team	Manager	655-8448
Alvin Buckwold Child Development Program at Kinsmen Children's Centre	Coordinator, Health Records and Patient Registration	655-1079
Community Services (PT, OT, SW) – RUH Room 2771		655-1464
FIT for Active Living	Manager	655-8950
Parkridge Health Record Department	Manager	655-3899 (fax) 655-3801
Sherbrooke Clinical Record Department	Manager	655-3631 (fax) 655-3727
Addictions Outpatients 8th Floor, Sturdy Stone Bldg	Manager, Administration Family Health Services	655-5805
Calder Centre 2003 Arlington Ave	Manager, Administration Family Health Services	655-5805
Borden Health Centre	Manager, Rural Development	655-5365
Delisle Health Centre	Manager, Rural Development	655-5365
Client/Patient Access Services (CPAS) 201-310 Idylwyld Dr. N.	Manager	655-4362
Home Care 201-310 Idylwyld Dr. N.	Administrative Coordinator Home Care	655-4423
Hearing Aid Plan 2nd Floor, Sturdy Stone Bldg	Manager, Administration Family Health Services	655-5805
Podiatry 9th Floor, Sturdy Stone Bldg	Manager, Administration Family Health Services	655-5805
Primary Health Services Scott Forger, City Center	Manager, Rural Development	655-5365
Rural Wellness Clinics	Manager, Rural Development	655-5365
Central Haven Special Care Home	Administrator	665-6180 (fax) 665-5540
Circle Drive Special Care Home	Administrator	955-4800 (fax) 955-2376
Dalmeny Spruce Manor Special Care Home	Administrator	254-2101 (fax) 254-2178
Extendicare Special Care Home	Administrator	374-2242 (fax) 374-2203
Langham Senior Citizens Home	Administrator	283-4210 (fax) 283-4212

LOCATION	*CONTACT*	*CONTACT NUMBER*
Lutheran Sunset Home	Administrator	664-0300 (fax) 664-0311
Oliver Lodge	Administrator	382-4111 (fax) 382-9822
Porteous Lodge	Administrator	382-2626 (fax) 382-2633
Saskatoon Convalescent Home	Administrator	244-7155 (fax) 244-2066
St. Ann's Home	Administrator	374-8900 (fax) 477-2623
St. Joseph's Home	Administrator	382-6306 (fax) 384-0140
Stensrud Lodge	Administrator	373-8680 (fax) 477-0308
Sunnyside Nursing Home	Administrator	653-1268 (fax) 653-7223
Warman Mennonite Special Care Home	Administrator	933-2011 (fax) 933-2782
Public Health Services • Idylwyld Health Centre • West Health Centre • North Health Centre • Southeast Health Centre	Manager, Disease Control	655-4609
Mental Health Services • Adult Community - 715 Queen St. - SCH - Ellis Hall, RUH • Child & Youth Services - 715 Queen St., SCH - Youth Services - Youth Resource Centre - CATU • Rehab MHS, Ellis Hall • McKerracher Centre	Coordinator of Centralized Intake will refer to the appropriate Program Manager	655-7950
Renal Program/Dialysis	Manager	655-5316
SaskatchewanTransplant Program	Manager	655-1053
Ambulatory Patient Education dept	Manager	655-2615
Ostomy/Wound Clinic	Main office	655-2138
Eye Care Center	Main office	655-8045
Central Sask. Immunodeficiency Clinic	Manager	655-6672