

CE LHIN Guidelines for Clinical Documentation: Vision and Guiding Principles

CE LHIN Clinical Informatics
Advisory Group

30 July 2009

Foreward

On behalf of the Central East Local Health Integration Network (CE LHIN) Clinical Informatics Advisory Group (CIAG), I am pleased to release the official **CE LHIN Guidelines for Clinical Documentation: Vision and Guiding Principles** document. The CE LHIN VP CNE group has reviewed and approved of this document for use across the CE LHIN.

This document reflects the work of the CE LHIN CIAG and builds upon the incredible spirit of partnership and good-will that we have all experienced since our kick-off meeting with Dr Lynn Nagle in April 2009. We have adapted much of the content for this document from other work in an effort to avoid “re-inventing any wheels”. This document creates and details a shared vision and shared guiding principles for one piece of the CE LHIN eHealth puzzle; clinical documentation.

The overarching vision for eHealth in the CE LHIN is both exciting and ambitious. The broad eHealth vision for the CE LHIN is:

“Better eHealth → better health”

The CE LHIN sees eHealth as an enabler, facilitating the electronic exchange of information across the continuum of care, and helping the LHIN to:

- Use information technology and information management to support people and families, and improve the health and safety of the population in the LHIN and beyond
- Ensure clinical information follows the person (with consent)
- Ensure the seamless transfer and referral of people among the LHIN partners and with providers outside the LHIN, while meeting privacy requirements
- Streamline business processes to facilitate efficiency
- Support providers in delivering care

The CE LHIN's goal to standardize clinical documentation across hospitals is a vital element and a prerequisite to help ensure that the CE LHIN eHealth vision becomes a reality.

This document is a start in the right direction. However, we do recognize that additional recommendations need to be put forth by us, with respect to some of the more detailed elements of clinical documentation (such as specific and shared methodologies for narrative notes and care planning). Furthermore, as you will see in Appendix A, future attention must be given to the work associated with creating and sustaining a shared quality clinical documentation practice setting in the CE LHIN. Some food for thought is included in Appendix A for your review. We expect that the clinical documentation business case being completed by Lynn Nagle will offer more information in this regard as well. This document is and will continue to be a living document that will grow and change with us.

The CE LHIN CIAG wishes to thank the CE LHIN VP/CNE group for your continued support of our work on a shared clinical documentation system. We look forward to continuing our work in this regard!



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Executive Summary

The proposed vision for clinical documentation is **CE LHIN Clinical Documentation is a standardized patient centered inter-professional record based on best practice that enables better patient outcomes.**

The CE LHIN CIAG proposes **four guiding principles** for CE LHIN clinical documentation. Clinical Documentation in the CE LHIN is:

1. **Patient centred and collaborative**
2. **Comprehensive and a complete record**
3. **Ensures and maintains confidentiality**
4. **Driven by best clinical practice**

Key elements associated with CE LHIN Clinical Documentation are summarized below:

1. Clinical documentation includes all forms of documentation by a doctor, nurse or member of the inter-professional team (physiotherapist, occupational therapist, dietitian etc) recorded in a professional capacity in relation to the provision of patient care.
2. Clinical documentation is a fundamental part of clinical practice. It demonstrates the clinician's accountability and their professional practice.
3. Clinical documentation is the basis for communication between health professionals that informs the care provided, the treatment and care planned, and the outcome of that care as a continuous and contemporaneous record.
4. Clinical documentation is a record of the care and the clinical assessment, professional judgement and critical thinking used by a health professional in the provision of that care.
5. Clinical documentation should be clear, concise, consecutive, correct, contemporaneous, complete, comprehensive, collaborative, patient-centred and confidential.
6. Clinical documentation must be patient focused and based on professional observation and assessment that does not have any basis in unfounded conclusions or personal judgements.
7. Clinical staff must be able to competently communicate effectively with individuals and groups using formal and informal channels of communication and ensuring documentation is accurate and maintains confidentiality.
8. Clinical staff is required to document in accordance with standards of practice of their profession and organizational policy and procedure.
9. Clinical documentation is often used to evaluate professional practice as a part of quality assurance mechanisms such as performance reviews, audits and accreditation processes, legislated inspections and critical incident reviews.
10. Clinical documentation systems should promote appropriate sharing of information amongst inter-professional teams.
11. Accurate and comprehensive clinical documentation is a valuable source of data for data coding, health research and a valuable source of evidence and rationale for funding and resource management.

12. Clinical documentation should record both the actions taken by clinical staff and the patient's needs and/or their response to illness and the care they receive.
13. Clinical staff has legislative, professional and ethical obligations to protect patient confidentiality. This includes maintaining confidential documentation and patient records.
14. Precautions must be taken to ensure that clinicians are fully informed of appropriate, safe and secure use of electronic information systems and the potential risks involved in using such systems in ensuring and maintaining confidentiality.
15. It should be assumed that any and all clinical documentation will be scrutinized at some point.

The diagram below helps to illustrate the key elements associated with CE LHIN Clinical Documentation.

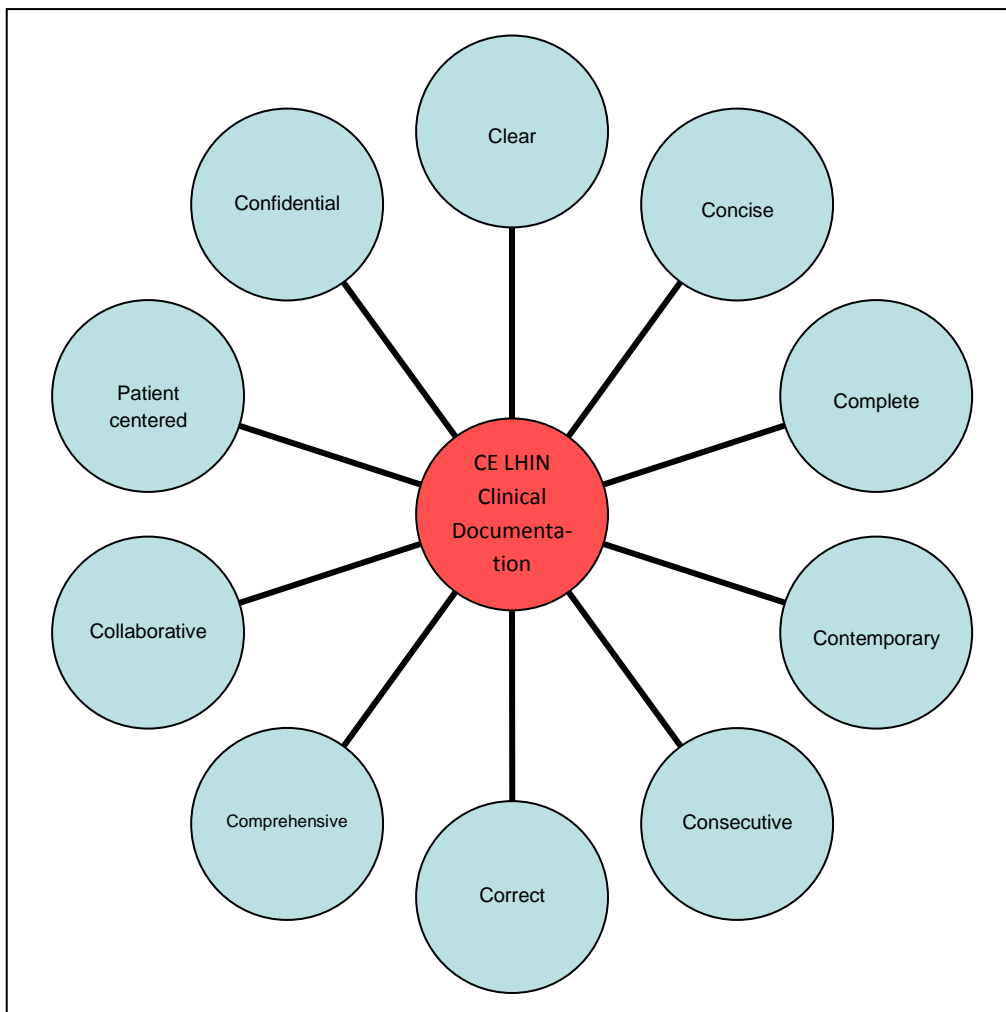


Diagram 1

Purpose of CE LHIN Guidelines for Clinical Documentation

These guidelines support CE LHIN clinical staff, employers, policy makers, and managers in clinical documentation practices and policies that demonstrate the professional obligation, accountability and legal requirements to communicate patient health information and clinical interventions in the public interest. It should be assumed that any and all clinical documentation will be scrutinized at some point.

Clinical documentation may include:

Any and all forms of documentation by a clinician recorded in a professional capacity in relation to the provision of patient care. This documentation may include written and electronic health records, images (photographs and diagrams), observation charts, check lists, flow sheets, assessments, narrative notes, interventions, tick sheets and documents associated with care planning.

Purpose of Standardized Clinical Documentation in the CE LHIN

Communication

Clinical documentation in health records is the basis for communication between health professionals. It informs the care provided, the treatment and care planned and the outcome of that care as a continuous and contemporaneous record. Documentation enables health professionals and other care providers to use current, consistent data, and care goals to facilitate continuity of care. Clear, complete, accurate and factual documentation provides a reliable, permanent record of patient care and outcomes, and is an accurate record of the history of the patient's health care.

Accountability

Clinical documentation demonstrates the clinician's accountability and records their professional practice. It may be used to determine responsibility of care providers and to resolve questions or concerns in relation to care required. The clinician's documentation may be used in relation to performance management, internal organizational inquiries and/or legal proceedings.

Legislative requirements

All regulated health professionals are required to make and keep records of their professional practice in accordance with standards of practice of their profession and organizational policy and procedure.

Quality improvement

Clinical staff can use clinical documentation to reflect on their practice and implement changes based on evidence. Documentation is evidence of the quality provision of care and services to the public. Clinical documentation may be used to evaluate professional practice as a part of quality assurance mechanisms such as performance reviews, audits and accreditation processes, legislated inspections and critical incident reviews.

Research

Clinical documentation is a valuable source of data for health researchers. It provides information in relation to clinical interventions, evaluates patient outcomes, patient care and is a concise record, essential for accurate research data, and evidence based practice.

Funding and resource management

Data accessed from clinical documentation can be used as an appropriate tool for identifying the type of care that patients require, the services provided and the efficiency and effectiveness of care. Any of these factors may impact on funding and resource allocation. Accurate and comprehensive documentation of interventions provides a valuable source of evidence and rationale for funding and resource management.

Guiding Principles for Clinical Documentation in the CE LHIN

Guiding Principle 1: Clinical Documentation in the CE LHIN is Patient Centred and Collaborative

Clinical documentation is patient centred, patient focused, collaborative and appropriate to the setting in which the care is provided and the purpose for which the information is recorded.

Clinical documentation must be patient-focused. Clinical documentation may record diverse information within and across services and settings. Given the diversity of care provided, clinicians must consider the purpose of documentation and how, by whom and for what purpose that information is to be used.

Effective documentation systems require regular review and revision.

Characteristics of Patient Centred Documentation:

1. documentation systems and practices are appropriate to the specific needs of the patient/patient population and context of the care
2. appropriate documentation systems enable and support shared documentation processes
3. provides a record of independent and collaborative actions with other health professionals or care providers (e.g. those ordered by another appropriate health professional)
4. is a contemporary, secure, and resource efficient system
5. documentation systems are relevant to the setting in which the care occurs (including patient held records, electronic records and mobile record systems)
6. identification of objective and subjective data occurs in documenting the assessment of the patient needs/health status
7. presents an individualized, comprehensive and current plan of care
8. is based on professional observation and assessment that does not have any basis in unfounded conclusions of personal judgements
9. identifies problems that have arisen and actions taken to rectify/address
10. frequency of documentation is consistent with professional judgement in relation to complexity/stability of patient, organizational policy, standards and legislation
11. has documented valid consent of any clinician proposed intervention or operation
12. holds accessible relevant previous/other documentation (including patient history, long and short term intervention, diagnostic investigations most recent previous documentation by other clinical staff)
13. possesses appropriate supporting documentation systems and forms
14. enables documentation of intervention via telephone (including information obtained and advice given)
15. it should be assumed that the patient may document on his or her chart in some settings.

Guiding Principle 2: Clinical documentation in the CE LHIN enables a comprehensive and complete record

Clinical staff have a professional obligation to maintain documentation that is clear, concise and comprehensive, as an accurate and true record of care.

The clinical documentation systems and processes adopted by the CE LHIN must support clinicians to document meaningfully, with ease and in harmony with their professional workflows.

Clinical documentation by clinical staff is an integral part of practice to ensure safe and effective care. Documentation is a record of the care provided, and the judgement and critical thinking used by a health professional in the provision of that care.

Documentation acts as evidence of the unique and important contribution of each staff member to health care. It forms the basis for evidence of care that can be used for research, legal analysis and determination, allocation of resources and as a primary communication between health professionals.

Characteristics of Comprehensive and Complete Clinical Documentation:

1. clear, concise, complete record of clinical care (including, assessment, plan of action outcomes and evaluation of care)
2. factual, accurate, true and honest record
3. avoids duplication of information
4. legible and non-erasable, permanent, retrievable, confidential, patient-focused and non-judgmental
5. representative and reflective of professional observations and assessment
6. timely and completed as close as possible after episode of care or event, preferably at the point of care
7. a complete record including completed forms, charts, methods and systems
8. chronological record of care (late entries recorded as soon as possible as to rectify the absence)
9. prefaced with date and time of care or event (including recording of late entries, changes or additions)
10. identifying details of person who provided / documented care
11. identifying of source of information (including information provided by another health care professional or provider)
12. inclusive of signatures (or initials) and professional designation of person recording information
13. contains meaningful and relevant information (avoids meaningless phrases such as '*slept well*' or '*usual day*')
14. minimize transcription of data
15. easily interpreted over time and after significant time has elapsed
16. avoid use of abbreviations (other than those approved and documented in CE LHIN policies)
17. detailed documentation in relation to critical incidents such as patient falls, harm to patients, or medication errors

Guiding Principle 3: Clinical documentation systems in the CE LHIN ensure and maintain confidentiality

Clinical documentation systems (including electronic systems) will ensure and maintain patient confidentiality, in all care settings.

Clinicians have legislative, professional and ethical obligations to protect patient confidentiality. It is essential that the confidentiality of that information be safeguarded and shared only as necessary to protect the interests of the person and to ensure the best outcomes of care. This includes maintaining confidential documentation and patient records.

Electronic information, mail and communication systems are increasingly used as effective means of maintaining and transferring documentation and information in the health care environment. Precautions must be taken to ensure that clinical staff is fully informed of appropriate, safe and secure use of electronic information systems.

It should be assumed that any and all clinical documentation will be scrutinized at some point.

Characteristics of Confidential Clinical Documentation

1. Ensures and maintains the confidentiality of the patient
2. Develop and implement practices that protect confidentiality of information and data when documenting in a record (including charts)
3. Records stored and archived confidentially
4. Confidentiality of electronic documentation and information
5. Systems and practices are in place that maximize the confidentiality of documentation and records in diverse settings

Guiding Principle 4: Clinical documentation systems and processes in the CE LHIN are driven by best clinical practice

Clinical documentation systems (including electronic systems) will be designed and used in a manner to reflect, comply with and support best clinical practice. Practice drives documentation.

There is a relationship between clinical documentation and clinical practice. Poorly designed clinical documentation systems and processes impinge on clinical practice in a way that is detrimental to the clinicians ability to practice, and can become a barrier to effective patient care. Good clinical documentation systems and processes are designed to enable clinicians to document as a natural part of their practice and workflow.

The best clinical documentation systems and processes are adaptable, and constructed to offer the clinician flexibility in practice. Furthermore, the best clinical documentation systems use documentation as a tool to organize communication and make decisions. Ideally, clinical documentation systems offer the ability to “layer information” for the clinicians; thus providing clinicians with both a summary or trend view of information as well as the option to view more detailed information and supporting documentation.

Characteristics of Clinical Documentation that is driven by practice

1. Reflects, complies with and supports best practice.
2. Documentation is completed as a part of practice and workflow.
3. Synergy exists between practice and documentation.
4. It is adaptable and flexible.
5. It is an effective method for communication and decision making.
6. It provides various levels of detail, depending on the clinicians' need.
7. Clinicians see value in it.

Appendix A – For Consideration

Creating and Sustaining a Quality Clinical Documentation Practice Setting in the CE LHIN

As CE LHIN providers partner in efforts to achieve quality practice settings across our region, we have a shared responsibility and legal accountability to create and maintain environments that support competent clinicians in providing quality, evidence based outcomes for our patients. In ensuring quality documentation practice, these documentation guidelines encourage employers, and clinical staff to incorporate strategies, policies and procedures that strengthen effective documentation practices within the work setting.

Strategies to maintain quality documentation practice include;

Organizational Support

- Effective systems to support accurate and concise documentation of practice
- Appropriate policies and procedures in relation to effective documentation systems, practices and management of patient health information
- Risk management strategies that support effective documentation of practice
- The provision of adequate time allocation to document appropriately and review previous documentation as part of patient care.

Leadership

- Encouragement of clinical staff to be involved in decision making in relation to selecting, implementing and evaluating documentation systems
- Implementing quality improvement processes related to effective documentation
- Promotion of documentation as an integral and core part of practice and professional responsibility.

Resources

- Access to an appropriate physical environment that supports and increases efficiency and confidentiality of documentation
- Reliable, accessible and appropriately maintained equipment
- Documentation systems and technology appropriate to/for the setting in which the care occurs.

Professional Development

- Appropriate information, education and orientation for staff in relation to documentation systems and practices
- Performance management processes that provide opportunity to improve documentation practices.

Communication Systems

- Documentation systems that promote appropriate sharing of information amongst the multidisciplinary team
- Effective exchange of information whilst ensuring and maintaining patient confidentiality
- Integrated progress notes for use by all disciplines and care providers
- Secure electronic data and transmission systems where appropriate

- Appropriate processes for patients to access information in relation to their care.

Responsive to Change

- Documentations systems and practices that are responsive to change, (eg in relation to changing models of care, legislation)
- Systems that are responsive to, and accommodate changing patient population needs

CE LHIN Clinical Documentation Policy

The CE LHIN partnership will need to ensure that we have documented policy, procedure and quality assurance mechanisms in place which clarify:

- the legislative requirements for documentation
- the minimum requirements for documentation
- format and type of documentation (including acceptable documentation tools and forms)
- the roles and responsibilities of the clinical staff in relation to documentation
- accepted abbreviations in the organization (including their agreed meaning)
- any requirements for witnessing or counter signing documentation (and the meaning and responsibility assigned to these practices)
- requirements for access, storing, archiving and retaining documentation
- requirements for documentation of verbal orders and provision of telephone advice/information
- requirements for confidentiality and privacy
- Consistent methods for communicating transfer information within the LHIN and also outside of the LHIN, and between other jurisdictions.

Monitoring of clinical documentation in the CE LHIN

An audit process is one component of appropriate risk management. An audit process will play an important role in monitoring quality and standard of care and the ability to produce accurate and complete coded data from available documentation and records. Audit tools developed at a local level to monitor the standards of documentation form the basis for review. The need to maintain confidentiality of patient information equally applies to documentation audit processes.

The CE LHIN partnership is encouraged to develop and implement an appropriate documentation policy and undertake regular auditing and monitoring of documentation and record keeping.

As maintaining the highest standard of patient care and the highest quality of coding rely significantly on the completeness, accuracy and currency of documentation, auditing and monitoring processes should focus on evaluating these areas.

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