Policy Name:	Policy Number:
CLINICAL DOCUMENTATION	**0105**
	Effective Date: **OCTOBER 17, 2021**
Approved By: Executive Team	Date Revised: October 17, 2021
Reason for Revision: Click on item below and select item from list. **CONTENT- Enter BELOW Reason for change Ex: Combined Policy ## and ##.** New Policy.	Next Date for Review: October 17, 2024
Section: Section 01 - Delivery of Care to Residents and Families	Page No: **Page 1 of 7**

Policy

OBJECTIVES

- To ensure clinical documentation within the Agape Hospice clinical record, a subset of the health record, supports health care providers in the delivery of high-quality resident care, strengthens resident safety, and promotes continuity of care.
- To ensure clinical documentation practices promote the Agape Hospice person centered care model.

PRINCIPLES

- All health care providers within the health system have legal, ethical, organizational and professional obligations (authority, responsibility, and accountability) related to the maintenance of clinical records. These obligations reflect how care is provided, facilitate communication among caregivers, and comply with the Health Information Act (HIA) and Agape hospice, policies and procedures.
- Clinical documentation is vital to the provision of high quality and safe health service(s) across the continuum of care. The clinical record is a critical component of collaborative care, resident and family-focused service, quality assurance and organizational learning.
- Effective clinical documentation promotes the care of both individuals and populations, while contributing to the improvement of the health care system as a whole.

APPLICABILITY

Compliance with this document is required by all Agape Hospice employees, members of the medical staff, Students, Volunteers, and other persons acting on behalf of Agape Hospice (including contracted service providers as necessary).

POLICY ELEMENTS

1. Compliance

1.1 This Directive, and any associated documents, apply to all aspects of clinical documentation, including clinical documentation processes, the development and implementation of clinical documentation practices, and the production of charting guides and norms that support clinical documentation.

1.2 All individuals shall adhere to all applicable clinical documentation requirements contained in:

a) Agape Hospice policies & procedures;
b) Professional practice standards;
c) Ethical standards;
d) Accreditation standards; and
e) Legislation and regulations.

2. Clinical Documentation Principles

2.1 Clinical documentation shall:

a) Support the practice of resident and family-centred care by promoting respect & dignity, information sharing, patient participation, honoring choices, and collaboration in influencing how health services are provided.
b) Be resident-centred, meaning accessible to residents (through approved channels) and attentive to residents' goals, perspectives and choices.
c) Support resident care and the professional practice process.
d) Be accurate, complete, clear, concise, legible, timely, and ordered to enable the health care provider to:
    i. Record the residents' perspective on their health care needs, goals, and preferences.
    ii. Access the needed information to make informed clinical decisions;
    iii. Communicate with the resident and other health care providers;
    iv. Integrate information to evaluate the current health status of the resident;
    v. Develop treatment goals and integrated plans of care in collaboration with the resident and other health care providers.
e) Support communication, and inter-professional collaboration.
f) Support evidence-informed decision-making using an inter-professional practice approach to care delivery that is sensitive to scopes-of-practice, regulation and professional practice standards, professional judgement, and individual circumstances.
g) Support safe practices and processes by utilizing a Just Culture where principles of appropriate accountability allow mistakes to be viewed as opportunities for learning and improvement.

h) Support Agape Hospice in protecting and securely managing information in its custody and control.
i) Be useful, accurate, efficient, and meet regulatory requirements while documenting decision-making, communication, and care.
j) Meet regulatory, legal, and Agape Hospice requirements regarding monitoring of health status, care effects, and outcomes of services provided to residents.

DEFINITIONS

Authorized Persons: means any individual allowable by legislation such as the Health Information Act [Alberta], professional regulations, Agape Hospice policies and job descriptions or users of a shared health record, where the user is subject to an information sharing agreement stating adherence to applicable Agape Hospice policies.

Clinical documentation: means the process by which health information is captured in electronic or written format on the clinical record to reflect patient care and to facilitate communication between providers. Clinical documentation also fulfills regulatory, legal and Agape Hospice requirements regarding status, care, and services provided to residents.

Clinical record: means the collection of all health records documenting health services provided and tracking the interactions with and communications between health care providers and the individual receiving health services.

Health care provider: means any person who provides goods or services to a resident, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Agape Hospice.

Health Information: means any or both of the following:
- Diagnostic, treatment and care information;
- Registration information.

Health record: means the collection of all records documenting individually identifying health information, in relation to a single resident.

Health service: means a service that is provided to an individual for any of the following purposes: protecting, promoting or maintaining physical and mental health, preventing illness, diagnosing and treating illness, rehabilitation and caring for the health needs of the ill, disabled, injured or dying, but does not include a service excluded by the HIA regulations.

Just culture: means an environment where everyone feels safe, encouraged, and enabled to discuss quality and safety concerns.

Resident: means and adult who receives or has requested health care or services from Agape Hospice and its health care providers or individuals authorized to act on behalf of Agape Hospice.

REFERENCES

Alberta Health Services Policy Resources:

- Clinical Documentation Directive (#1173), Clinical Documentation Process (#1173-01)

Alberta Health Services Resources: Clinical Documentation Framework
Health Information Act (Alberta)

Procedure

1. Authority to Document Health Information

1.1 Only authorized persons shall:
   a) Add health information to the clinical record for clinical documentation purposes.
   b) Add health information to the health record for administrative purposes.
   c) Transcribe documented health information to the health record (e.g. transcription).

1.2 Adding health information to the clinical record includes any contribution of data, information, or records to an entry (e.g. entering or capturing data or information, attaching photos, and uploading documents).

2. Responsibility for Completing Clinical Documentation

2.1 The health care provider delivering the health service(s) shall complete clinical documentation in the clinical record unless:
   a) A situation described in Section 2.2 applies.

2.2 In certain circumstances, an alternate health care provider (i.e. someone other than the health care provider delivering the health service), may be designated to enter health information on the clinical record. Such circumstances may include:
   a) When acting as a designated recorder (e.g. during a life-threatening event). The recorder documents the names of the health care providers involved, their role, all actions taken, and the resident's outcome or response; or
   b) where there is imminent risk of harm to the resident if information is not added to the clinical record, and the health care provider who provided the health service is not available to add the health information to the clinical record within an appropriate amount of time given due consideration to the risk

involved. A person with authority shall be notified and may direct an alternate authorized person to reduce this risk by adding the appropriate information to the clinical record.

3. Authenticating a Clinical Documentation Entry

3.1 Clinical documentation must be authenticated by the health care provider who created the entry.

3.2 When a health care provider's initials are used in a paper record for any clinical documentation purpose, a signature must be associated with the initials for authentication.

a) All health care provider's will clearly print their name, initials, professional designation, and sign the signature sheet at the beginning of each residents' health record.
b) Each entry in the Multidisciplinary Progress Notes (MPR) will be completed with the health care provider's signature and professional designation.
c) Each entry in the Flow Sheet will be completed with the health care provider's initials.

3.3 Co-signatures or co-initials may be used where the meaning or purpose of the co-signatures or co-initials is clear.

4. Timely Entry

4.1 Clinical documentation must:

a) be entered at the time of the event or as soon as possible thereafter;
b) document care that has been provided by the writer unless the health care provider is referring to resident interactions and/or interventions that are planned for the future but have not yet been started; and
c) be completely by signing.

4.2 When clinical documentation date and time are different from the resident interaction/intervention date and time, or when the clinical documentation is entered out of chronological order, the entry shall include:

a) the documentation date and time; and
b) the resident interaction/intervention date and time.

4.3 An entry should never attempt to preserve the chronological order of the interaction/intervention date and time by entering an artificial or inaccurate documentation date and time.

4.4 The frequency of entries in a clinical record depends on the situation and should reflect:
   a) the acuity of the resident's condition;
   b) the degree of risk associated with the treatment of care.

5. Clinical Documentation Content Guidelines

5.1 Clinical documentation shall:
   a) Be a complete record of health service(s) provided to the resident including the health care provider's observations, assessments, and communication.
   b) Document consent, as required.
   c) Document observations and discussions objectively and respectfully, refraining from any characterizations, assumptions, or personal bias of the resident, family members, or other health care providers.
   d) Document adverse events.
   e) Reflect information collected directly from the resident or clearly indicate the identity of the individual or health care provider providing the information.
   f) Contain only pertinent information that is essential to enable the health care provider to carry out the intended purpose.
   g) Detail, accurately and clearly, interactions and communications that occur during the provision of health services.
   h) Reflect any applicable assessment data, problem and/or diagnostic statements, plans of care and/or treatment, stated goals and/or desired outcomes, implementation plans and/or intervention(s), outcome evaluations, and any other statements regarding the details of a health service provided.
   i) Support and outline any health service provided, including any resident response and/or change in condition indicating the need for further or varied interventions.
   j) Be based on the needs and circumstances of a resident.
   k) Enable members of a collaborative health team accessing a shared medical record to make appropriate decisions, respecting continuity of care and the treatment needs of a resident.
   l) Reflect significant changes in resident condition or health services provided in a way that can be easily reviewed and interpreted over time and throughout the life of the resident.

6. Revising Clinical Records

6.1 Any health care provider, or individual subject to this Directive, who notices an entry containing incorrect or incomplete information shall notify the health care provider who created the entry.

6.2 Additions, corrections, and deletions (collectively referred to as “revisions”), shall be made by the health care provider who created the entry, except when the circumstances detailed in Section 2.2 apply.

6.3 Revisions to a clinical record shall not remove or obscure previously recorded information such that the originally recorded information is no longer visible or retrievable.

6.4 Revisions shall, along with the amended information, clearly indicate the amending date, time, and identity of the individual making the change.

6.5 Removal of information from a completed record shall clearly indicate that the information should no longer be considered but the information must still be readable and retrievable (e.g. a single line drawn through the text or electronic information removed from current view but not deleted from the system).

6.6 Amendments containing additional information to replace or supplement a previously recorded entry may be entered by any health care provider who provided care to the resident providing the revision follows approved processes and does not remove or obscure previously recorded information.

7. Auditing

7.1 Auditing of clinical documentation shall be used to support, measure, and continuously improve the clinical documentation process.