RISKCHECK
BY MARSH CANADA LTD.

Fall 2023

Patient Information and Documentation

Healthcare entities have the duty to provide safe and quality healthcare services to its patients and community; as part of this, they must ensure that the appropriate measures are in place for clear communication amongst members of the healthcare team and the patient. As part of this, the documentation of patient information is essential to ensure the safe and quality delivery of healthcare services, while providing the opportunity to share and record patient information in an organized, accurate, and confidential manner.

As part of their approach to ensure clear and accurate documentation of patient information, healthcare entities will need to consider its range of risks across all settings and address them through a comprehensive management plan. In doing so, they must take steps to strengthen and standardize their policies, procedures, and training to ensure that its healthcare practitioners understand are able to satisfy their organization, professional, and ethical duties, requirements, and obligations.

The following guidance highlights key areas of considerations for healthcare entities as it relates to patient information and documentation. It should not be seen as an exhaustive list and should be used in conjunction with policies and procedures, professional standards, as well in compliance with local laws and regulations, as some of the recommendations made in this document may be legally required.

1. Policies and Procedures

Establishing a policy and procedures will be essential in providing guidance to healthcare practitioners across all roles and settings on patient documentation and its role in providing safe and quality healthcare services. In addition, the requirements outlined by healthcare entities should be in alignment with professional and ethical duties, requirements, and obligations.

- ☐ Develop and review, at least annually, a comprehensive suite of policies and procedures that address and provide guidance in the following areas:
  - ☐ Documentation of patient information; and
  - ☐ Amendment to documentation of patient information
- ☐ Each of the above policies and procedures should include but not limited to the following:
  - ☐ Commitment to upholding best-practices for documentation of patient information;
  - ☐ Establishment of where the policy and procedures are enforced;
  - ☐ Articulates accountability of practitioners part of the healthcare team:
    - ☐ Employees (e.g. nursing, allied health);
    - ☐ Independent practioners (e.g. physicians, midwives); and
    - ☐ Students.
- ☐ Articulates documentation duties, obligations and requirements; and
- ☐ Articulates unacceptable documentation practices;
- ☐ Clearly defines and provides examples of documentation of patient information;

- ☐ Clearly defines and provides examples of documentation across all settings;
- ☐ Available support services internal and external to the organization;
- ☐ Ensure that training regarding the policy is provided to all individuals and groups, as required; and
- ☐ Ensure the policy is made available to all individuals and groups, as required.

2. Training

Establishing a role-based training program is essential to ensuring that all healthcare practitioners are aware and understand their respective duties, requirements, and obligations as it relates to the documentation of patient information. The development, implementation and review of a role-based training program should be in alignment with organization, professional, and ethical standards.

- ☐ Develop a role-based mandatory training program that enhances awareness and understanding on duties, obligations, and requirements for the documentation of patient information Specifically, the training should address the following:
  - ☐ Documentation of patient information for all roles and settings.
  - ☐ Consequence of non-compliance with policies and procedures;
  - ☐ Availability of internal and external resources for healthcare practitioners;
  - ☐ Measures to support effective documentation across the organization; and
  - ☐ Measures in place to protect patient across the organization.
- ☐ Establish a training schedule, which require all healthcare practitioners to receive training upon hire and to receive refresher training on a regular basis.

3. Documentation Practices

Building awareness and a clear understanding of effective documentation practices will ensure that healthcare practitioners are able to share and record patient information in an organized, accurate, and confidential manner with the healthcare team, which helps to ensure the safe and quality delivery of healthcare services. The following highlights documentation practices, which healthcare entities can adopt as part of their approach for all roles and settings:

- ☐ Articulates standardized terminologies and acronyms;
- ☐ Articulates documentation practices:
  - ☐ Named and signed;
  - ☐ Dated and time-stamped;
  - ☐ Fact or information-based;
  - ☐ Clear and concise;
  - ☐ Accurate and complete; and
  - ☐ Legible and readable.
- ☐ Articulates unacceptable documentation practices:
  - ☐ Use of jargon;

- ☐ Use of subjective information;
- ☐ Lack of date and time stamped documentation;
- ☐ Lack of signature on documentation entry;
- ☐ Failure to document safety/harm incident involving the patient;
- ☐ Failure to document omitted medication or treatment; and
- ☐ Failure to document change in patient condition or treatment.

☐ Clearly defines and provides examples of documentation of patient information relating to:

- ☐ Physician order and progress notes;
- ☐ Nursing and allied health progress notes;
- ☐ Health history and assesmsent notes;
- ☐ Medical history and administration notes;
- ☐ Transfer of care report and notes; and
- ☐ Discharge summary.

☐ Clearly defines and provides examples of documentation across all settings:

- ☐ Emergency department;
- ☐ Inpatient areas; and
- ☐ Outpatient areas.

Summary

As part of delivering safe and quality healthcare services, healthcare entities must take the appropriate measures to ensure its practitioners share and record patient information in an organized, accurate, and confidential manner with members of the healthcare team and the patient. As part of this, they need to adopt the appropriate measures, which include policies, procedures, training, and systems to ensure that healthcare practitioners understand and satisfy their obligations when it comes to the clear and accurate documentation of patient information.