Alberta Health Services

DIRECTIVE

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CLINICAL DOCUMENTATION PROCESS

SCOPE
Provincial

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Not applicable

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Clinical Documentation Directive

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NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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OBJECTIVES

- To outline fundamental **clinical documentation** processes affecting the Alberta Health Services (AHS) **clinical record**, a subset of the **health record**, that must be followed by all **health care provider**s in all care settings, regardless of documentation technology or media.

APPLICABILITY

Compliance with this document is required of all Alberta Health Services employees, members of the medical and midwifery staffs, Students, Volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

ELEMENTS

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 (e.g. administrative health information such as appointment information kept outside of the clinical record; and registration information added as part of an admin function to the clinical record); and

c) transcribe documented health information to the health record (e.g. dictation/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) professional standards specifically permit an alternate person to complete the documentation; or

b) a situation described in Section 2.2 applies.

2.2 In certain defined 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 **patient**'s outcome or response; or

b) where there is imminent risk of harm to the patient 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 by:

a) including their name, applicable role, professional designation or job title, and by clearly signing the entry; or

b) following a defined process for authentication in a clinical information system.

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.

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 patient interactions and/or interventions that are planned for the future but have not yet been started; and

c) be completed by signing, saving, and/or filing immediately.

4.2 When clinical documentation date and time are different from the patient 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 patient 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 patient's condition;

b) the degree of risk associated with the treatment of care; and/or

c) any specific program and/or unit requirements.

4.5 In a computer-downtime situation, applicable downtime procedures shall be followed and retrospective entries in the clinical record made accordingly.

5. Clinical Documentation Content Guidelines

5.1 Clinical documentation shall:

a) be a complete record of health service(s) provided to the patient including the health care provider's observations, assessments, and communications;

b) document consent as per the AHS *Consent to Treatment/Procedure(s)* Policy and associated Procedures;

c) document observations and discussions objectively and respectfully, refraining from any characterizations, assumptions, or personal bias of the patient, family members, or other health care providers;

d) document adverse events as per the AHS *Reporting of Clinical Adverse Events, Close Calls and Hazards* Policy and associated Guideline;

e) reflect information collected directly from the patient 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) where applicable, be entered in the appropriate structured data fields to improve patient safety, reduce errors in transferring records between media, and ensure the most efficient and accurate communication of patient information;

j) justify, support and outline any health service provided, including any patient response and/or change in condition indicating the need for further or varied interventions;

k) be based on the needs and circumstances of a patient;

l) 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 patient; and

m) reflect significant changes in patient condition or health services provided in a way that can be easily reviewed and interpreted over time and throughout the life of the patient.

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). The method of deletion or removal of information varies depending on the media. Professional judgment may be required to ensure the method chosen is consistent with the guiding principles contained in the *Clinical Documentation* Directive.

6.6 Addenda and 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 patient providing the revision follows approved processes and does not remove or obscure previously recorded information. Minor additions or changes to previously recorded information may be made within the original entry providing the requirements of Sections 6.1 to 6.5 are met.

7. Auditing

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

7.2 Individual departments and programs are responsible to ensure an adequate program to establish and perform clinical documentation audits, as appropriate.

DEFINITIONS

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

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

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 good or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

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 person.

Health service, for the purposes of this document, 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.

Patient means an adult or child who receives or has requested health care or services from Alberta Health Services and its health care providers or individuals authorized to act on behalf of Alberta Health Services. This term is inclusive of residents, clients, and outpatients.

REFERENCES

- Alberta Health Services Policy Resources:
  - *Clinical Documentation* Directive (#1173)
  - *Collection, Access, Use, and Disclosure of Information* Policy (#1112)
  - *Consent to Treatment/Procedure(s)* Policy (#PRR-01) and associated Procedures (#PRR-01-01~05)
  - *Reporting of Clinical Adverse Events, Close Calls and Hazards* Policy (#PS11) and associated Guideline (#PS11-01)
- Alberta Health Services Resources:
  - *Clinical Documentation* Framework
- Non-Alberta Health Services Resources:
  - *Health Information Act* [Alberta]
  - *Health Professions Act* [Alberta]
  - *Health Disciplines Act* [Alberta]

VERSION HISTORY

Date	Action Taken
Click here to enter a date	Optional: Choose an item
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