ADMINISTRATION

Policy & Procedure

Title	**ENTRIES INTO HEALTH RECORDS**	Date Effective	**December 9, 2019**
Document #	**AD-09-145**	Date Reviewed	
Scope	**ALL EMPLOYEES, SITES AND FACILITIES**	Date Revised	
Approved By	**CLINICAL ADVISORY COUNCIL**	Signature	***Original signed by C. Ritzer***
Managed By	**REGIONAL MANAGER HEALTH INFORMATION MANAGEMENT**		

1.0 PURPOSE

1.1 To identify individuals authorized to make entries into health records.

1.2 To create accurate and complete health records which maintain their integrity when used as legal documents.

1.3 To facilitate documentation in health records that complies with the provisions of *The Personal Health Information Act* ("PHIA").

1.4 To promote documentation in health records that is respectful of the client, the client's family, and members of the health care team.

1.5 To articulate standards for writing orders and integrated progress notes.

2.0 DEFINITIONS

2.1 **Approved Health Record Forms:** documents and templates, including stickers, stamps, screens, tabs, and fields created for the purposes of recording client information into paper-based or electronic health records which have been vetted and endorsed by site and regional forms standards setting approval bodies.

2.2 **Client:** an individual who accesses and/or receives health care related services from a Northern Health Region (NHR) facility or program. A client may be a patient in an acute care setting, an elder in a personal care home, or client in a community program or facility.

2.3 **Electronic Record:** for the purposes of this policy means the electronic patient record (EPR) or the electronic medical record (EMR).

2.4 **Employee:** unless otherwise specified, refers to all employees, medical staff, students, volunteers, board members, contractors, contract workers, agency personnel, and other individuals performing work activities within or on behalf of the NHR.

2.5 **Finalized Electronic Entry:** also known as a locked electronic entry means a saved version of an entry into an electronic record which cannot be changed and requires special actions such as a correction, amendment, addendum, or late entry to modify the recorded information.

2.6 **Health Records:** personal health information compiled by individuals authorized to make entries on approved health record forms and maintained by facilities, sites, or programs of the NHR as the official record of health care provided to a client. Health records, including electronic records and paper-based health records are the physical property of a facility, site, or program of the NHR. For the purposes of this policy, health records include clinical records as defined in *The Mental Health Act*.

2.7 **Legislated Health Professionals:** employees who are licensed or registered to provide health care under an Act of the Legislature, or who is a member of a class of persons designated as health professionals in *The Personal Health Information Act* (PHIA) regulations.

2.8 **Late Entry:** documentation that was not recorded in the health record immediately or soon after the point of health care; and may be out of sequence with other entries into the health record.

2.9 **Non-Legislated Health Professionals:** employees who do not fit the definitions of a legislated health professional or support staff and who have a role in providing health care and documenting their actions in health records.

2.10 **Orders:** medication, diet, or general orders for client care given by authorized clinicians who are caring for a client. Orders are categorized as follows:

- **Fax Orders** those written and authenticated by a legislated health professional who gave the order which are transmitted to the location where care is being provided by a facsimile machine.
- **Protocol Orders** any approved evidence informed practice tool (care maps, clinical protocols, clinical practice guidelines, clinical algorithms, standing orders and standard orders),
- **Telephone Orders** those written or entered in the health record by a legislated health professional on behalf of another legislated health professional who has communicated the order by telephone.
- **Verbal Orders** those written or entered in the health record by a legislated health professional on behalf of another legislated health professional who is unable to write or enter the order themselves; for example, in an emergency situation.
- **Written Orders** those entered and authenticated in the health record by a legislated health professional who is giving the order.

2.11 **Unfinalized Electronic Entry:** also known as an unlocked electronic entry; means an entry made into an electronic record which is not complete and normally requires further action by the author within a defined time frame to make it a finalized electronic entry.

3.0 POLICY STATEMENT(S)

3.1 Entries into the health record are to be appropriate, accurate, complete and timely.

3.2 Entries into the health record are made directly on approved health records forms or into templates which are electronically generated from health information systems and form part of the health record; e.g. diagnostic imaging reports, operative reports, etc.

- Other forms of documentation pertaining to clients such as printouts of e-mail communications between health care providers are not acceptable replacements for concurrent and direct documentation into the health record and are not filed or retained on the health record.

3.3 Those individuals authorized to make entries into the health record are identified in AD-09 145 Appendix A Health Care Professionals Authorized to Document in the Health Record.

3.4 All entries into the paper-based health record, including signatures and printed names are written or printed legibly using a ballpoint pen with permanent black or dark blue ink. Gel pens, non-permanent marker, erasable ink, and pencil shall not be used.
Red ink may be used to highlight (underline, asterisk) critical patient information such as allergies and key vital signs. No other colored ink is to be used.

3.5 Orders entered in the health record including verbal orders, telephone orders, protocol orders, fax orders, and written orders adhere to policies for CPS-08-125 Verbal Telephone Orders and CPS-08-40 Medication Order Writing and conform to the following principles:

3.5.1 All legislated health professionals have order-writing authority. What is ordered by each legislated health professional is determined by the clinical program responsible for the standard of care provided to client and stipulates those orders:

- that require approval by the provider of record prior to implementation; and
- that do not require approval by the provider of record prior to implementation.

In making these determinations and requirements, the clinical program decisions are guided by the scope of practice of the legislated health professional and are consistent with that professional's role on the specific health care team.

3.5.2 Legislated health professionals are accountable for each telephone or verbal order they give or receive from another legislated health professional.

3.5.5 Legislated health professionals in student roles have all medication orders countersigned by a legislated health professional before implementation. Non-medication orders may be implemented prior to a countersignature if discussion with the appropriate legislated health professional has confirmed that the student's role on the team is to write non-medication orders. The student indicates this on the order sheet. For example, a medical student would document: "Discussed with Dr." A legislated health professional countersigns all non-medication orders written by students within 24 hours.

3.5.6 If a legislated health professional questions an order and after discussion no agreement can be reached, a note indicating this shall be entered in the integrated progress notes and the matter is referred to the provider of record by one or both parties with a request for resolution.

3.6 Requests by a client or their personal representative for correction of entries in the health record follows established procedures set forth in AD-07-120 Correction of Personal Health Information and AD-07-110 Access, Correction and Disclosure – Clinical Records under *The Mental Health Act*".

4.0 PROCEDURE / RESPONSIBILITIES

4.1 Individuals authorized to make entries into the health record are responsible to:

- review the health record as appropriate;
- make entries reflective of their scope of practice, role and involvement with care, treatment and services which are planned for, and provided to the client;
- make entries reflective of the needs of the client, the treatments and interventions provided, and the client's response and outcome;
- document according to the charting methodology or system adopted by the facility, site, program, or discipline

Anyone reading the record should clearly be able to determine:

- What care or service was provided;
- To whom was the care or service provided;
- By who was the care or services provided;
- When the care or service was provided;
- Why the care or service was provided;
- The client's response and outcomes to the care or service provided.

4.2 **Entries into the health record**

Entries into the health record are appropriate, accurate, complete and timely. All persons authorized to make entries into the health record are responsible to:

4.2.1 Adhere to all legal requirements and ethical expectations for documentation set forth by provincial legislation, professional governing bodies, regulatory bodies, the NHR and/or facility, site, or program specific policies and guidelines.

4.2.2 Make entries concurrent with health care provided that:

- include the date and time;
- are in chronological order at the time the event or observation took place or as soon as possible thereafter;
- are not made in advance of the time of the event or observation; and
- when applicable, identified as a "Late Entry" along with the date and time the entry is being made. Within the body of the note indicate the date and time of the event or observation.

4.2.3 Accurately identify the client and include the client's name, date of birth, health record number, and their provincial health care card number. When a provincial health care card number is not applicable, include the client's alternate health care number; e.g. Canadian Armed Forces number.

4.2.4 Make entries which are client focused, factual and concise. Recording of opinions or suspicions shall be clearly stated as such.

4.2.5 Document in a manner that adheres to NHR's policy HR-02-55 Respectful Workplace.

4.3 **Dates on Health Record Entries**

The date is written or displayed as two (2) numeric characters for the day, three (3) alpha characters for the month and four (4) numeric characters for the year; e.g. 31-Mar-2012. The time is written or displayed using the 24-hour clock; e.g. 1315 hours.

4.4 **Late Entries**

4.4.1 **Paper based health record**

- All late entries include the date and time the late entry was recorded along with the date and time that the health care event occurred.
- Late entries are documented as soon as possible.
- When a pertinent entry is missed or not documented in a timely manner, a later entry is used to record the information in the paper based record.

4.4.2 **Electronic health record**

- A late entry to a structured note in the (e.g. an Integrated Progress Note) is documented under the application's default date and time (the current date and time) and in the first free text field, the person making the late entry shall enter "Late Entry" and the date and time when the health event(s) occurred.

- A late entry to a flow sheet in the electronic record shall have the default, or current date and time changed to the date and time of the event or assessment so that graphed observations display accurately. The person making the late entry into a flow sheet shall insert “Late Entry” in the comments field of the column header to alert members of the health care team that the event or observation entered was done out of sequence.

4.5 Signatures on Health Records Entries

4.5.1 Are authenticated by their handwritten signature or an electronic signature. The signature includes the initial or full first name and surname of the person making the entry along with their professional designation.

4.5.2 Initials may be used in place of full signatures at facilities, sites or programs using the Signature Sheet Form #: NHR_0322when this practice is not contravened by another practice or standard.

- Initials in place of a full signature are not acceptable on consent forms, anesthetic records, operative reports, intra-operative records, orders, cumulative blood product records, resuscitation records and health record face sheets.

4.6 Telephone Orders or Verbal Orders

received by Legislated Health Professionals are to adhere to policies for CPS-08-125 Verbal Telephone Orders and CPS-08-40 Medication Order Writing.

4.7 Corrections to Paper based Health Records

In the paper based health record corrections (changes or modifications), amendments (clarifications) and addendums (additions) to entries are done in a manner that is immediately recognizable by end-users of the paper-based health record.

4.7.1 Any corrections made to paper-based entries into the facility health record, are made by:

- drawing a line through the incorrect entry ensuring that the inaccurate information is still legible. Do not obliterate the original entry with marker, whiteout, or correction tape, or by writing over the entry;
- writing “error” on top of the incorrect entry and initialing and dating the entry; and
- documenting the correct information. If the error is in a narrative note, it may be necessary to enter the correct information on the next available line, documenting the current date and time and referring back to the incorrect entry.

4.7.2 Corrections to paper-based entries into the health record which have been entered in the wrong health record are made as follows:

- the entry in the wrong health record follows procedures established in Section 4.7.1. The individual making the correction flags the health record in a way that alerts other employees to remove the information when responding to a disclosure or access request; and
- the information is then entered in the correct health record, according to policy. A photocopy of the correct information is acceptable provided that all of the incorrect identifying patient information is blocked, the copy is clearly legible, and a note is included indicating why the photocopy is being included in the health record.

4.8 Corrections to Electronic Health Records

In the electronic record, corrections, amendments, and addendums shall be viewable by end-users in the electronic audit trail and reflect the original content, author, date, time and the new content, author, date and time.

4.8.1 Corrections made to electronic-based entries into the health record, are made by:

- appending a note to a finalized electronic entry; and
- adding, correcting or removing information from an unfinalized electronic entry.

4.8.2 Corrections to electronic-based entries into the health record which have been entered in the wrong health record are made as follows:

- an entry in the wrong health record is cancelled with a cancellation reason indicated;
- documentation elsewhere in the health record that is impacted by the wrong entry shall be identified and corrected. In the event a finalized electronic entry is impacted, an immediate request shall be placed to the health information services department (or other authorized person) for the entry to be deleted and an addendum to be entered explaining the situation;
- the information is entered in the correct health record according to policy; and
- documentation with a cancelled documentation status will not be included in response to a disclosure or access request.

4.8.3 Corrections to orders in the electronic record which have been entered in the wrong health record are made as follows:

- an order entered in the wrong health record is discontinued with a discontinuation reason noted;
- documentation elsewhere in the health record that is impacted by the wrong entry is identified and deleted and an addendum entered to explain the situation;
- the information is then entered in the correct health record according to policy; and
- documentation with a discontinued documentation status will not be included in response to a disclosure or access request.

5.0 RELATED DOCUMENTS

5.1 AD-09 145 Appendix A Health Care Professionals Authorized to Document in the Health Record

5.2 AD-07-110 Access, Correction and Disclosure – Clinical Records under *The Mental Health Act*"

5.3 AD-07-120 Correction of Personal Health Information

5.4 CPS-02-CH.10 Charting for Long Term Care

5.5 CPS-02-CH.20 Integrated Care Plan for Long Term Care

5.6 CPS-08-40 Medication Order Writing

5.7 CPS-08-125 Verbal Telephone Orders

5.8 HR-02-55 Respectful Workplace

5.9 MS-01-100 Minimum Documentation Standards Acute/Transitional/Long Term Care

5.10 Signature Sheet Form #: NHR_0322

6.0 REFERENCES

6.1 Health Professions Registrars, http://www.gov.mb.ca/health/legislation/contact.html . Accessed on June 24, 2010.

6.2 HIROC. (2017). Strategies for Improving Documentation Lessons from Medical – Legal Claims

6.3 Manitoba Government. (2019). The Mental Health Act C.C.S.M.c.M110 Retrieved from http://web2.gov.mb.ca/laws/statutes/ccsm/m110e.php

6.4 Manitoba Government. (2019). The Personal Health Information Act C.C.S.M.c.P33.5 Retrieved from http://web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php

6.5 Rozovsky, L.E. and Inions, N.J. (2002). *Canadian Health Information*. Butterworth's Canada Ltd. 2002

6.6 Rozovsky, L.E and Rozovsky F.A. (1984). The Canadian Law of Patient Records. Butterworth's Canada Ltd.

6.7 The College of Physicians and Surgeons of Manitoba, Statement No: 104 Medical Computer Systems: Security and Self-Audit; PR/05-90, Revision PR/05-98Part 5 Patient Records https://cpsm.mb.ca/about-the-college/standards-of-practice-of-medicine

6.8 Winnipeg Regional Health Authority. (2013). Entries into Health Records # 75.00.060

7.0 REVISION & REVIEW DATE(S)

Revised (R)
reviewed (r)