Connect Care

Clinical Information System

DOCUMENTATION Norms

Nursing and Allied Health

Alberta Health Services

Connect Care

Documentation Norms (Nursing and Allied Health)

Norms

The Connect Care Clinical Information System (CIS) serves all who provide care where Connect Care CIS is the record of care. Documentation Norms are about how Connect Care CIS users collectively improve the benefit-to-burden balance of documentation activities.

Documentation norms relate to professionalism and accountability. Our expectations of one another, and the digital behaviors that express those expectations, promote good documentation practices.

Documentation Norms complement Minimum Use Norms. Both documents highlight the importance of collaborative, care-centric, comprehensive, current, credible, credited, curated and chronicled documentation. In addition, the following references: Clinical Information Sharing Approach (CISA) and Information Sharing Compact inform minimum use and documentation norms by affirming expectations and accountabilities between Alberta Health Services (AHS) and Connect Care CIS users, including responsibility for the completeness and quality of the health record.

Policy

AHS has organizational accountability for standards-compliant clinical documentation. Relevant policies and procedures include Clinical Documentation Principles and a Documentation Process that must be followed by all clinicians. Documentation Norms align with Policy.

Applicability

Connect Care CIS Documentation Norms apply to all Clinicians that generate documentation through direct entry, or voice recognition, anywhere and anytime across the care continuum. There is a specific document relevant to Prescribers, whereas these specific norms carry specific expectations for Nurses, Allied Health, Nutrition, Pharmacy, Aids and Assistants.

Intent

Connect Care CIS clinical documentation should be:

1. Collaborative

All health care providers share responsibility for the quality, credibility and usefulness of the health record while respecting the contributions of one another.

2. Care-Centric

Enabling best possible health services and outcomes while minimizing negative impacts of administrative or non-clinical documentation.

3. Comprehensive

Through concise capture of all information needed to support effective clinical decision-making, avoiding unhelpful duplication.

4. Current

Timely entries that will enable the entire health care team to align with current plans.

5. Credible

Drawing from primary sources, validating accuracy with patients, and correcting erroneous information.

6. Credited

Appropriately attributing external and internal sources, noting when others' documentation is updated, modified, or copied.

7. Curated

Balancing recording of new observations with refining of enduring observations.

8. Chronicled

Telling the patient's story in a way that preserves the narrative while exposing important developments.

Documentation Activities

Different CIS tools support different documentation activities, e.g. Flowsheets, Navigators.

Each of the following activities is facilitated by a specific CIS tool or activity and workflow. The location of activities within CIS navigators or other user-interfaces may vary in different clinical contexts (e.g., emergency, critical care, inpatient, and outpatient). However, the products of documentation activities are always available for integration into composite documentation tools, such as letter communication templates or after-visit summaries.

Connect Care CIS Documentation Norms relate to each of the following types of documentation activities, further described in the sections that follow.

Clinical Documentation

What is it?

Clinical documentation is the process by which we record health observations, assessments or plans so that they can be shared with other members of the health care team. All forms of clinical documentation serve communication, collaboration and coordination.

There are two categories of clinical documentation: Best practices vary by category.

1. Progress documentation records new or changed findings, clinical progress, or otherwise indicates what is unique or important about a defined period within a larger care encounter or episode. This is reflected in Progress notes or Flowsheet activity. Progress notes are typically transactional documents. They should highlight clinically important developments since the last summative documentation.

2. Summative documentation gathers all information pertinent to an encounter or episode, organizes observations, and offers a plan directed to care goals. Examples of summative documents include assessment reports, and transition of care documentation.

Why does it matter?

The Connect Care CIS health record will capture large amounts of health information, especially for patients suffering from chronic health problems. Good clinical documentation increases the 'signal' to 'noise' ratio, improving the likelihood that important information will be viewed.

When summative documentation is done well, the patient's story is preserved despite focus on one or more specific health problems. When progress documentation is done well, new developments in the patient's journey are easily identified. Well-structured notes are easier to read, find, filter, scan and trend.

When documentation is not done well, the patient's story is obscured. Indeed, misuse of copy-paste and smart links drives much of the dissatisfaction with digital health records. Incorrect, inefficient or ineffective documentation erodes the credibility and usefulness of the record.

Who is responsible?

All health care providers have clinical documentation management responsibilities. These may be primary, where the clinician is entirely accountable for what they record. They may also be secondary, where the clinician oversees trainees or learners. Clinical documentation norms apply whether one is an original author, editor, or a consumer of documentation started by others.

Clinicians are responsible for the total content of their signed documentation, irrespective of where they obtained information from.

How is reducing duplicative records done?

Good clinical documentation is concise and unique and reduces information burden for both note authors and consumers. Information gathered by any multidisciplinary team can be cross-referenced.

Duplicative, discipline-based documentation silos are discouraged. A well-organized clinical electronic record allows related information to be referenced and linked.

Clinical Documentation

Copy-Paste and Copy Forward

Copy-paste and Copy Forward practices can save documentation entry time in the short term but increase documentation review time in the long term. When used irresponsibly, these practices contribute to chart-bloat, propagate error, obscure accountability, and decrease confidence in the record.

In general, copy-paste is not needed and should not be used. When content from another entry is being brought into a current note, it is recommended to use Copy Forward as the attributes carry forward to identify the original author of the content.

If copying from Connect Care CIS to a separate information system, this must be done with extreme caution as there is risk of a privacy breach.

CIS users who copy-paste for convenience (i.e., as a template for the next note) should verify that all copied information remains correct, pertinent, and relevant. The origin of copied information must be attributed and must acknowledge the original context in which the copied information was generated. Clinicians are responsible for clearly identifying who performed interventions that are documented. They must also preserve properties and protections of sensitive copied material (e.g. break-the-glass or masking).

Progress Documentation

When documenting multiple times during an encounter, each progress record should emphasize what has changed since the prior note. This keeps the chart lean and makes it easier for other users to appreciate trends. Efficiency is favoured over comprehensiveness.

Do

- Be concise. Avoid adding information readily available in standard chart sections.
- Standardize progress and procedure note formatting. Use provided note types with standardized subheadings (e.g., SOAP). Use text automations to speed documentation within sections.
- Document what is pertinent.
- Keep documentation timely (as close as possible to the time of observation).
- Validate (e.g., “problems, medications and labs reviewed”) rather than replicate.
- Interpret and analyze. Highlight trends, significant developments, and specific outcome markers.
- Use comment field in flowsheet when applicable.
- Communicate errors back to the original author to adjust accordingly.

Don’t

- Don’t re-enter patient-level (problems, history) or encounter-level (medications) information into a note instead of pulling from other parts of the chart, unless it is essential to emphasize the state of that information at one point in time.
- Don’t routinely pull in data (e.g., vitals, labs) readily available elsewhere unless directly relevant to decisions made during the event documented.
- Don’t pull in clinical content using smart tools that implies observations were completed when they were not.
- Don’t repeat investigation data when interpretive comments suffice.
- Don’t modify, replicate, or delete documentation of another user.

Clinical Documentation

Summative Documentation

Summative documentation serves assessment or transition in care by generating a note that can stand on its own. It may be the basis for a communication sent to a referring provider. In summative documentation, comprehensiveness is preferred over efficiency.

It is important in summative documentation to summarize multiple parts of the chart. Accordingly, summative notes are more likely to benefit from text automations that pull information (such as problems, allergies, medications, and investigations) into the note to reflect the state of that data at the point of analysis. Some summative documentation can be gradually built as the patient's journey unfolds.

Ideally, the only work remaining at discharge or transfer is to reconcile problems and medications before confirming care plans and follow-up accountabilities.

Do	Don't
• Use text automations (e.g., SmartPhrase, SmartText) to pull information into the summary to avoid re-entering and assuring accuracy. • Convert imported content (e.g. medication list) to text so that it can be edited for brevity and readability. • Use summative documentation as an opportunity to curate, correct, and update transactional documentation.	• Don't use communication tools (e.g. letter, fax) for summative documentation when a chart note could suffice and can be pulled into the communication tool. • Don't create summative documents outside the CIS, expecting to attach these communications to the chart. • Don't pull in excessive chart information if the summative documentation stays within the Connect Care CIS and is not intended for external sharing. • Don't incorporate the summation or analysis of others without proper attribution.

Clinical Scales Scores and Tools (CSST)

Copyright permission is required for all CSST's. Copyright permissions are complex. Using copyright materials without proper permission exposes both AHS and the user to potential lawsuits.

Do not scan a CSST if full copyright permission has not been confirmed. Tools that do not have copyright permission for full build may be captured in a flowsheet row where only the name of the tool is stated and the total score.

Health Problem Documentation

What is it?

The Connect Care CIS health Problem List appears in all charts in all contexts. Diseases, disorders, injuries and health conditions that have an impact on, or could be impacted by a patient's current care are included on the Problem List.

Health problems are standardized labels for conditions, diagnoses or risks. Problems map to codified terminology. Accordingly, when the term "Problem" is used in Connect Care CIS, it refers to a specific medical condition.

Why does it matter?

The Problem List helps clinicians identify and manage a patient's medical problems at any point along the continuum of care. There are many CIS functions affected by Problem List content.

A patient's health problems determine which ordering tools (Order Sets, SmartSets, Protocols, etc.); documentation aids (templates, flowsheets, forms, etc.); coordination aids (Express Lanes, Therapy Plans, etc.); decision supports (alerts, reminders, etc.); patient resources (handouts, questionnaires, etc.); and professional billing prompts are offered to speed workflows. Problem lists are pulled into progress notes, consultations, discharge and transition summaries. Finally, patient registries, reporting tools, quality metrics and chronic disease management dashboards reference patient groupings defined by well-specified problems.

Messy Problem Lists impede workflows. Good Problem Lists provide scaffolding for a clear, concise and impactful health record. They connect workflows within Connect Care CIS, and beyond, through patient and provider portals.

Who is responsible?

All Prescribers share responsibility to update and manage the Problem List, especially those problems they have entered themselves.

Problem List reconciliation (resolve, revise, or promote) occurs at first encounter, care transitions, or appropriate intervals. Prescribers should update the Problem List in a way that befits their context (inpatient, outpatient), specialty, accountability, and training.

Connect Care CIS does not micro-manage Problem List editing rights, instead expecting professionals to contribute responsibly while knowing that all entries and edits are tracked. Editing the Problem List will not be locked down through security, rather this will be managed through norms.

One of the greatest challenges for teams is to jointly maintain a Problem List. Different Prescribers may have different notions about how specific a problem is (e.g., "Chronic Obstructive Lung Disease" vs "Emphysema"), or whether a problem is active and relevant to ongoing care. Use of a digital health record does not absolve one from professional courtesy. When editing an existing Problem or consolidating several Problems into one unifying diagnosis, it is important to help other Prescribers recognize changes and appreciate the reason(s) for the changes.

Health Problem Documentation

How is it done?

Listed Problems are active Problems. A Problem is active if it relates to the patient's current health or treatment. Inactive or past Problems can be listed elsewhere in the chart, usually as part of the patient's medical or surgical history. Goals, issues, or targets can also be listed elsewhere (e.g., care plans).

Problem List Content

The Problem List is attached to the patient and is maintained by Prescribers. It is visible across the continuum of care (inpatient, outpatient, continuing, etc.). For a medical condition to be added to the Problem List, it should be:

- **Persistent:** The Problem is expected to be relevant over multiple encounters, whether in the shorter or longer term.
- **Clinically Relevant:** The Problem should be under active management, as may be reflected by diagnostic, therapeutic, rehabilitative, palliative, or other interventions. Problems that no longer impact, or are impacted by, a patient's current care should be resolved (removing them to an archive list) or entered or transferred to the Medical or Surgical history.
- **Specific:** The condition or diagnosis should be as specific as possible.

Appropriate Problem List Entries

Category	Example
• Chronic medical problems requiring ongoing therapy or surveillance. • Recurring acute medical problems or conditions subject to exacerbations. • Problems requiring continuing or recurring prescription medical therapy. • Problems requiring continuing investigation or monitoring. • Acute problems while under active management. • Ongoing dependency or abuse • Chronic psychiatric disorder	• Asthma, Hypertension, Chronic Kidney Disease, Recurrent urinary tract infections. • Recurring shoulder dislocation. • Migraine headaches, Sciatica, Anxiety. • Thrombosis for which anti-coagulation therapy continues. • Abdominal pain, Headache, Low Back Pain. • Alcohol dependence. • Opiate dependence. • Depression, Post-Traumatic Stress Disorder, Anxiety.

Health Problem Documentation

Problem List Views

The Problem List has a special organization in inpatient contexts, with sections for Hospital and Non-Hospital problems. It complements, not duplicates, the Patient Problem List by highlighting issues specific to the current encounter. These Hospital Problems are reviewed by the Attending Prescriber at discharge to determine which are resolved and which need to remain in the enduring Health Problem List.

The Attending Prescriber is responsible for identifying or adding hospital-specific problems. Trainees and Consultants may add problems or may communicate with the Attending Prescriber to update Hospital Problems.

Multidisciplinary Problem List

The Multidisciplinary Problem List is attached to an inpatient encounter. It displays any of the evidence informed care plans that have been initiated for the patient. Listed issues may include conditions or risks (e.g., adult confusion, compromised skin integrity, risk of aggression) or preventative measures (e.g., functional ability and falls). These Care Plans are acute care focused and are intended to be resolved prior to discharge with any remaining goals or interventions being continued in the outpatient environment in the Care Planning Activity.

Health Problem Documentation

Problem Histories

The Past Medical History and Past Surgical History are comprehensive listings of all significant past problems, procedures, and surgeries. Although it is possible for problems to appear in both Past History and Problem Lists, such overlap should be kept to a minimum.

When reviewing or reconciling Health Problems, those that are not actively managed should be transferred to the Past Medical History. Resolved surgical problems or procedures should be transferred to the Past Surgical History. Past histories should be as concise as possible. They should not be cluttered with self-limited, temporary, inconsequential, or remote issues lacking continued clinical importance.

Problem List Management

Do

- Contribute: Add a new problem or update an existing problem to make it more precise, based on current clinical assessment.
- Clean: If an entry was never a problem, delete it; if no longer a problem, resolve it; if of historical significance, transfer it to the medical or surgical history.
- Refine: If informational developments permit, make a problem more specific.
- Combine: If two problems prove duplicate, move important descriptive information from the less to the more documented problem and resolve the lesser problem.
- Prune: Keep any problem-embedded “overview”, “goals” or “care plan” narrative succinct and relevant to ongoing care.
- Distinguish: Exacerbations of existing problems that trigger admission can be listed as Hospital Problems but otherwise Hospital Problems should be unique to the current encounter.

Don’t

- Don’t Duplicate: Don’t add a new problem when a less specific existing problem could be revised.
- Don’t Butt-in: Don’t delete or override active problems, overviews, or comments if you are not the Prescriber managing the problem.
- Don’t Clutter: Don’t add diagnoses that are self-limited or do not require active management with diagnostic, therapeutic, rehabilitative, or palliative interventions.
- Don’t Destroy: Don’t delete problems outright, unless they were clearly entered in error, or do not meet the criteria for a problem outlined above; instead, “resolve” otherwise unhelpful problems, and copy any useful overview information to a more appropriate problem entry.

Diagnosis Documentation

What is it?

Health encounters occur for a reason. Diagnosis management is about how responsible Prescribers and/or Clinicians indicate the primary reason for the health encounter, or the conclusion reached as a result of that encounter.

Diagnosis documentation applies in all health contexts across the continuum of care (e.g., inpatient, outpatient, emergency, continuing). The specificity of an encounter diagnosis may not be at the level of a definitive medical disease. It may remain at the level of a symptom, sign, or condition yet not associated with an underlying cause. Irrespective, the encounter diagnosis is recorded using standardized medical terminology and is codified for multiple purposes. These include Best Practice Advisories, After Visit Summaries and Discharge Summaries, cohort groups, patient registries, clinical analytics, billing, and reporting purposes.

Why does it matter?

Encounter diagnoses may impact follow-up actions, after-visit summaries, enrollment in clinical investigations, inclusion in patient registries, and content of analytics reports or initiation of chronic disease management plans. Encounter diagnoses may reach a level of specificity meriting inclusion on the Health Problem List or Medical or Surgical Histories.

All care team members rely on clear and precise encounter diagnoses when searching the CIS for encounters that may relate to specific issues or diseases. Indeed, most health record encounters cannot be closed until an associated diagnosis is recorded.

We serve patients better when we can map their disease experiences to others like them. Opportunities for personalized and precision medicine depend upon accurate encounter diagnoses in the context of comprehensive Problem Lists.

Who is responsible?

Clinicians may independently record discipline- specific reasons for non-prescriber health encounters. However, Prescribers are typically responsible for selecting and recording of a most responsible diagnosis.

How is it done for Outpatient Encounters?

There is a section for “Visit Diagnoses,” where preference lists, speed buttons, or search allow easy selection of common diagnoses. Any Problem List element can be selected as an encounter diagnosis.

Diagnosis Documentation

Do	Don’t
• Specify one primary visit diagnosis (outpatient) for non-Prescriber health encounters.	• Don’t specify diagnoses at a level less specific than justified by investigations and assessments known at the encounter conclusion.

Medication Documentation

What is it?

Medication documentation is about how medication decisions are recorded, communicated, validated, implemented, supported, and followed. It promotes safe, effective, and appropriate drug therapy as part of patient-centered care. The Medication List is a record of medications in active use by a given patient at a given time.

Key Medication Documentation Terms

Medication Management	Patient and health team collaborate to optimize safe, effective, and appropriate drug therapies.
Best Possible Medication History (BPMH)	Complete and accurate list of all the medications a patient is taking, created using at least two information sources; including a patient or patient's proxy interview.
Medication reconciliation (link to policy)	Formal process in which Clinicians collaborate with patients to ensure accurate and comprehensive medication use information is communicated consistently across transitions of care.
Clinical Medication Review	Examination of patient medication use in the context of clinical conditions and interventions in order to improve health outcomes.

Nursing, Pharmacy, Midwives, Dieticians, Nurse Practitioners, and Physicians can complete the BPMH. (Medication Reconciliation policy PS-05 (ahsnet.ca)) BPMH is a documentation activity completed by health care team members. Reconciliation uses a BPMH to establish what a patient should be taking and what they are actually taking, then clarifies changes, adjustments, or discontinuations associated with the start or end of an episode of care.

Medication Documentation

Why does it matter?

Medication-related error is a common cause of health system-associated harm, with miscommunication at the root of most errors.

Ongoing maintenance and periodic review of a comprehensive medication list is essential for clinical decision support (e.g., drug-drug, drug- disease, drug-lab, drug-dose and drug-reaction checks), medication administration, adverse reaction surveillance, patient education, patient adherence, and system-to-system health record transfers.

Medication reconciliation is particularly sensitive to norms. It can be inconvenient, but vitally important. It ensures that patient medications (prescribed and self-administered) are reviewed and validated at transitions of care and periodic reviews.

Who is responsible?

Many multidisciplinary health care team members contribute to medication management practice, and resources vary in different settings. In any one practice context, there should be clear communication about which clinicians can assist with preparation of a BPMH.

Medication reconciliation (decisions and documentation of decisions about medications) is a Prescriber responsibility.

How is it done?

The collection of the best possible medication history occurs in both outpatient and inpatient workflows. Reconciliation of prior medications with new medications occurs at care transitions (i.e., admission, discharge, transfer) as well as periodically during ongoing care management.

Good practice is reflected by clear documentation of any differences between intended and actual medication use. Any reasons for change from prior to temporary or ongoing new medication lists requires proper documentation.

Medication Documentation

Do	Don't
• Validate directly with the patient or patient's proxy to ascertain the latest home medication list, actual use, and likelihood of non-adherence. • Inquire about regular, as needed (PRN), over the counter (OTC). • Record source(s) of medication information during best possible medication history, medication review and medication reconciliation activities. • Document clinically pertinent patient's reasons for medication discontinuation, dose adjustments, substitutions, or new prescriptions.	• Complete adverse reaction documentation if revealed during BPMH activity. • Don't rely exclusively on past discharge or consultation medication lists, or drug dispensing records (e.g., Pharmacy Information Network, PIN in Netcare EHR). • Don't let BPMH slip from essential clinical service to administrative hassle. • Don't use comment boxes to specify route, dose, and frequency of use.

Adverse Reaction Documentation

What is it?

Ensuring documentation of a patient's adverse reactions to medication, immunization, food, supplement, and environmental exposures is a minimum use expectation. Managing this documentation involves validating prior reactions, characterizing current reactions, and removing disproven reactions.

Why does it matter?

Adverse reactions are prominently displayed in the Connect Care Patient Storyboard, visible to all clinicians for all encounter types, and are a core attribute of the patient record. Broad awareness helps to avoid harms when medications, dressings, nutrition, and topicals are considered for use. This information is routinely pulled into clinical reports, such as admission, discharge, and transition summaries. Many decision supports, including checks during medication ordering, depend upon accurate adverse reaction data.

All clinicians need to trust warnings about exposures that could harm patients. If the majority of clinicians enter and ratify that information, then reaction lists are clarified, alerts are more meaningful, and the time spent by clinicians to find or review reactions decreases.

Consistent use of standardized descriptors ensures that decision supports (e.g., alerts and reminders) have few false positives and negatives. Consistency also facilitates quick review by being able to find the same descriptors, in the same locations, used in the same way.

Who is responsible?

Patients are responsible for forthright reports of past reactions when asked by health care providers. Health care professionals then characterize the type, severity, and confidence of a reaction. CIS users are responsible to learn how to use the standardized descriptors when checking the completeness, precision, and accuracy of reaction reports. Clinicians are also responsible, as part of professional standards and legislation, for adding, editing, or reconciling adverse reaction information imported from other systems.

How is it done?

Entering, editing, and reviewing adverse reactions is in the "allergy/contraindications" activity which can be accessed through the patient Storyboard and navigators or activity tabs in all CIS contexts.

Adverse Reaction Management

Do	Don't
• Include and classify all clinically significant reactions. • Reflect an estimate of certainty in the note section. • Correct entries which are erroneous (e.g. 'allergy to Furosemide', where patient is known to be taking Furosemide without adverse reaction). • Pull in (rather than re-enter) Adverse Reactions to external communications, using smart tools (e.g. SmartPhrase). • Don't include known side effects of medications unless it is important to warn future prescribers to consider particular sensitivities.	• Don't use tools other than the allergy/contraindications activity or the linked adverse drug reaction flowsheet to document Adverse Reactions. • Don't repeat adverse reaction data in notes unless it is essential to record the state of reactions at a specific point in time.

Encounter Documentation

What is it?

Clinical encounters occur in both inpatient and outpatient settings and are reflected in the Connect Care CIS as a package of information related to a specific visit, admission, or intervention. 'Opening' and 'Closing' these encounters affects the state of the encounters which, in turn, affects what other Connect Care CIS users can see or do. Accordingly, polite encounter management is a matter of norms.

Why does this matter?

Encounters left in an 'open' state can limit actions of others until the encounter is 'closed' by the responsible provider, indicating that his or her work is complete. Open encounters may be interpreted as being in a provisional or incomplete state, with content that cannot be treated as definitive.

Prompt encounter management can promote focused clinical documentation while avoiding a build-up of encounters that will require more time to manage later when the encounter is a distant memory.

Who is responsible?

The responsible provider for an encounter is accountable for signing encounter content and closing the encounter event.

Elements of a complex encounter, such as a multidisciplinary outpatient clinic visit, can be signed by the professionals contributing those elements (e.g., allied health assessment) even though the responsible prescriber closes the encounter itself. An appointment can be shared by multiple providers, but is only scheduled to one provider, and that provider is the one responsible to close the encounter.

How is it done?

An encounter is 'closed' when the responsible provider completes and 'signs' essential tasks, then selects a prominently displayed 'close encounter' button.

Encounters do not have to have all questions answered or all results available to be closed. It is possible to append documentation later when key investigation results become available. For this reason, encounter tasks should be completed as soon as possible after provider-patient interaction, with the encounter ideally closed the same day. Some encounters may take longer to document, but no outpatient encounter should be left unattested (signed and closed) for longer than 3 weeks after provision of outpatient or inpatient service.

Encounter Documentation

Do	Don't
• Attempt to close all encounters at the end of each encounter or at the end of each day, to avoid any chance the patient will present for a subsequent encounter (planned or unplanned) with information from an open encounter unavailable.	• Don't defer signing encounters simply because test results are awaited.

Charting by Exception

What is it?

Charting by Exception (CBE) was introduced in the mid 1980's as a way to help streamline documentation in healthcare settings and to free up time from documentation activities to allow staff to spend more time with patients.

CBE is built on an assumption that the patient has displayed a normal response to all interventions or assessment components unless an abnormal response is documented. This assumption also presumes that the clinician did, in fact, assess the patient and made the observation or judgment that the response was normal. Adoption of a Charting by Exception model replaces the former thinking of "if you didn't chart it, you didn't do it" with "all standards are met unless otherwise specified". Additional documentation is only required if there is a deviation from the guidelines, protocols, and procedures associated with each outcome statement or assessment parameter.

	Use description	Definition	User
Within Defined Limits (WDL)	Outlines a basic, day-to-day, head-to-toe general assessment and survey that can be used by any nurse to identify and record significant or exceptional findings. When WDL is called out, focused assessments are not required.	A method of documentation used to Chart-by-Exception (CBE) that relies on established predetermined standards to document clinical findings considered significant or remarkable.	Nursing, Allied Health
Within Normal Limits (WNL)	Used to indicate findings that are normal (organizationally validated standards are specified), fully functional without impairment.	No concerns identified. No impairment observed. Structure(s) and function appear as specified.	Allied Health
Within Functional Limits (WFL)	Used to indicate findings that are typical and are not explicitly measured (no specified standard).	No significant limitations in structure(s) and/ or function identified. Individual is able to perform task or activity in a timely manner with satisfactory result	Allied Health

Focused assessment – refers to examination methods relevant to assessing a specific concern or problem.

Charting by Exception

Why does this matter?

Charting by exception is intended to:

- Ease documentation burden.
- Provide guidance on findings that are exceptions/remarkable when charting by exception.
- WDL and WNL assessments help establish baseline findings and allow clinicians to monitor trends.
- Ensure health care provider performs the same type of assessment to monitor general well-being and overall health status of their patients.

Who is responsible?

Flowsheets containing WDL will be completed primarily by nurses, but other health care providers will rely on information documented in these flowsheets.

WDL documentation is found in the Inpatient (e.g. Neonatal Assessment, Peds/ PICU Assessment, Adult Basic Assessment) and Emergency Department applications. Further efforts are required to ensure parameters or norms are documented for all WDL and WNL assessments.

To promote CBE, AHS should continue to examine documentation and develop norms where appropriate to better realize the benefits. The existing parameters and norms may require review over time as scientific evidence and norms change over time.

How is it done?

WDL parameters and their individual limits identify what is expected to be assessed. The WDL method does not require unremarkable, individual parameter findings to be documented. This supports easy identification of findings that are remarkable, requiring further documentation. WDLs provide an AHS-approved, standardized, day-to-day, head-to-toe general assessment and survey.

Charting by Exception

WDL

Do	Don't
• Use WDL when parameters are defined and conversely, refer to organizationally defined parameters when using WDL. • Take into consideration variations in WDL parameters depending on patient population. • Complete all WDL parameters within that body system (Document WDL only when all WDL parameters are met). • When WDL is documented, presume all WDL parameters within that body system are assessed. • Descriptively document any findings encountered outside the defined limits (Document against WDL parameters within the body system).	• Don't replace the need for focused assessments with WDL. • Don't use WDL documentation for treatment or other interventions that should be documented elsewhere in the chart. • Document WDL when assessment was not performed.

WDL

Do	Don't
• Use WNL when parameters are defined. • Refer to organizationally defined parameters when using WNL. • Use for WNL documenting treatments and interventions when parameters are defined.	• Don't replace the need for focused assessments. • Don't document WNL when assessment was not performed.

Flowsheet Activity

What is it?

Flowsheets are documentation tools designed to track a large amount of patient data over time.

Why does this matter?

Flowsheets offer integration data collection and communication across disciplines as nurses, ancillaries, and support staff all enter data into the patient's flowsheet. This data can populate other activities to assist with health care decision making across disciplines. For example, when a nurse validates input and output volumes for a patient in the Intake/Output flowsheet, the volumes automatically appear in the Intake/Output activity, which a physician reviews.

Who is responsible?

Clinical staff are the primary users of documentation flowsheets. Other members of the healthcare team may also use flowsheets to document patient-specific information, e.g. Spiritual Care Providers.

How is it done?

Information is documented on each row of the flowsheet as validated by the clinician.

There are tools to aid with comprehensive documentation while saving clinicians' time. These include Copy Forward and Macro functionality:

Copy Forward: Allows users to copy data from a previous time column/assessment into a new time column. Copying data forward helps users improve the speed of documentation, especially in critical care areas or with assessments that stay stable over time. After the users copy the latest data, the nurse can modify the data elements that have changed.

Some rows are configured to not allow Copy Forward functionality. Even if enabled, however, there is documentation that should always be entered manually, not via copy forward (i.e. a patient's vitals).

Insert Data and Smart text: Users can create notes directly from the Flowsheets activity and flowsheet navigator sections by pulling that data directly into the note. This feature allows users to create notes without having to access the Notes activity or a Notes navigator section.

Flowsheet Management

Do	Don't
• Copy Forward when there is no change from a previous assessment that you have completed. • Review prompts as Copy Forward will overwrite fields with values. • Modify data elements as required after Copying Forward. • Use SmartLinks to pull in relevant flowsheet data into a summative note.	• Don't Use Copy Forward for an assessment that you have not completed yourself. • Don't use Copy Forward for first time documentation.

Flowsheet Activity - Macros

What are macros?

Flowsheet macros are an efficiency tool which speeds documentation. Macros are best used for flowsheets that need to be completed frequently and have multiple elements that do not change.

Why do they matter?

Clinicians can use macros to document common sets of data in flowsheets. Macros allow users to document substantial amounts of data with fewer clicks instead of documenting each flowsheet row individually.

What are the types of Macros?

Public – configured for broad use by all clinicians who have access to the flowsheet template, can be restricted to certain login departments.

Personal – created by clinicians, can be shared with other individual clinicians, can be converted to Public by IT (if indicated).

Who is responsible?

Clinicians are responsible for determining if it is appropriate to use a macro and, when used, for ensuring the flowsheet data is an accurate representation of the patient's condition.

Key point: Macros will not overwrite clinician entered data prior to applying a macro. Clinicians can undo a macro's documentation using the Undo button, until the data is filed/saved.

How are macros used?

While similar in some ways to copy forward, flowsheet macros are a separate feature with different use cases.

For many workflows, macros provide “default answers”. Clinicians can document pertinent findings and then apply the macro to fill in the rest of the documentation.

E.g., assessment of a peripheral IV site. The normal values are entered so it is obvious that those elements have been assessed when viewed by other clinicians, while the use of the macro ensures that less time is spent entering repetitive data.

After a macro is applied the clinician must review all documented values (macro-related and non-macro related) for accuracy and make any necessary updates before filing the flowsheet.

Some flowsheet rows are restricted from being included in a macro and will not show up in any macro (public or personal). Rows containing formulas, vital signs, MAR actions and MAR documentation are examples of rows that are restricted from macros.

Macros are available within the flowsheet activity, navigators, narrators, and assessments in the LDA Avatar. Once a macro has been created in Hyperspace, it is available in Rover. SmartForm-based flowsheet navigators and narrators currently do not support Macros (but are on Epic’s development roadmap).

Flowsheet Macro Use

Do	Don’t
• Use Macros for workflows that require documentation of multiple data elements that seldom change from entry to entry. • Use Macros for first-time documentation on a patient.	• Don’t use Macros where most of the information changes at each entry (i.e. no efficiency is gained from the use of the Macros). • Don't use Macros to document incidents/events.

Care Plans (Inpatient)

What is it?

A Care Plan is a standardized, evidence-based recommendation for the care of inpatients with specific concerns (e.g. functional ability; skin integrity). They include multidisciplinary interventions to support optimal patient care during an acute care admission.

Why does this matter?

Improved patient outcomes are seen with the use of care plans. Increased patient satisfaction and trust are gained because of consistent care and better understanding of responsibilities for care and communication amongst all health care providers.

The Care Plans in Connect Care CIS were developed specifically for AHS to address areas of patient care that we know either cause harm or extend the length of stay. They are also situations in which consistent practice is paramount.

Fortunately, there is a lot of evidence behind these patient conditions that guide us for how to intervene. Care Plans are acute care focused and are intended to be resolved prior to discharge with any remaining goals or interventions being continued in the outpatient environment in the Treatment Plan/Care Planning Activity.

Who is responsible?

Care Plan education has focused on nursing designations but all members of the interprofessional team will have access to the Care Plans.

How is it done?

Standardized Care Plan templates will be added to the patient encounter based on clinical judgement and/or the results of certain screening tools (for example, the Skin Integrity Care Plan will automatically be applied to a patient who has a Braden Score below 18). Care Plans, such as Functional Ability, will be applied manually when a clinician feels that the goals and interventions included in the Care Plan would benefit the patient's care.

Although the tasks under each one of the Care Plans are pre-configured and are meant to support practice by providing an evidence informed standard list, these Care Plans can be individualized for each patient by choosing the goals and tasks that are most appropriate to the patient. Further patient specific details can be added in the notes that accompany the Care Plan.

Care Plan

Do	Don't
• Review the standardized content included in Care Plans that are applied automatically based on screening tools. • Implement the interventions outlined in the Care Plan. • Communicate the goals and interventions to other team members involved in the patient's care. • Use the Care Plan notes to document care that is provided to help the patient achieve the goals.	• Don't ignore Care Plans that appear on a patient chart even if you didn't put it there as it may have been triggered by a screening tool. • Don't forget to consider adding a Care Plan throughout a patient's stay when the patient condition changes. • Don't use the Care Plans in isolation. Include the whole care team in discussion about goals, interventions and progression. • Don't forget to track progress towards goals when documenting on the Care Plan.

Care Planning (Outpatient) and Collaborative Goals and Treatment Plan Flowsheet (Inpatient)

What is it?

A personalized, multidisciplinary tool for planning, documenting and tracking care over time in ambulatory or community care settings. It's also used to assign tasks to therapy assistants. Clinicians and teams can use this tool to intentionally engage clients and families in a shared decision-making process resulting in functional client-centered goals. The client is the expert on their values, preferences, and motivations and the provider is the expert on the condition and the rehabilitation process.

Why does this matter?

Interdisciplinary teams will now have a shared, consistent, customizable, template for the documentation of collaborative goals and treatment plans for each patient, practice location and team structure. There is shared location to view and contribute to the patient's care plan without duplicating or overlapping documentation. Therapy assistants will refer to this tool for task assignment. This tool does not replace face-to-face communication which should occur when tasks are assigned to therapy assistants.

Having a shared location for care plan documentation will improve communication of the patient's goals and treatment interventions between providers within and across the care continuum. Clients can have increased participation in the development of their own meaningful care plan and confidence that their treatment team is working in a coordinated way to help them work towards goals that are important to them.

Collaborative goal setting improves client outcomes. When clients and families are actively involved in making decisions about their goals, their engagement, satisfaction, and motivation improves. In practice, this translates to improved clinical outcomes, greater client commitment in rehabilitation, improved self-management, fewer no shows or cancellations, and fewer readmissions to rehabilitation after discharge.

Who is responsible?

As the Care Planning tool is shared, all members of the care team share responsibility for initiating, updating and maintaining an accurate and functional tool. This will look different in each setting where the tool is used. Discussions about process for use in your setting and responsibilities is recommended.

How is it done?

In the outpatient Care Planning activity, a problem can be entered in a free text box. In the inpatient flowsheet, up to 6 goals can be entered in in order of priority. In the outpatient tool, priority can be assigned to the problem (High, Medium, and Low) as well as the date of onset and a date the problem is resolved. Goals related to a problem are then established together with the patient.

Goals are patient-stated and related to what is important to them through a collaborative approach. Goals can be short-term or long-term. From the patient-stated goals, the provider can then use clinical expertise to form individualized tasks that are aimed at getting the patient to achieve their goals. These are the agreed upon actionable items. Tasks can then be linked to Therapy Assistant delegation.

Care Planning (Outpatient) and Collaborative Goals and Treatment Plan Flowsheet (Inpatient)

Care Planning (Treatment Plan) Process Norms

Step 1. (Outpatient only) All Treatment Planning in an outpatient setting must be linked to an episode of Care. Episodes of care can be created by a member of the interprofessional team.

Step 2. (Outpatient only) By opening the Care Planning (Treatment Plan) Activity, clinicians can load a Care Planning template (AHS Collaborative Goals and Treatment Plan or AMH Treatment Plan).

Step 3. (Outpatient only) A "Problem" is identified, a description of the problem can be entered in a free text box, clinicians will be able to note the priority of the problem (high, medium, and low), the date of onset, and the date the problem is resolved, and problem comments are smart text enabled.

Step 4. Goals are at the patient level-patient-stated/focus. Whether they are short term or long term, goals are associated with the Problem, progress of goals can be noted as on track, progressing, not progressing, discontinued.

Step 5. Tasks are related to the patient's goals and a shared decision-making process is used to identify the treatment plan, clinician and or the

inter-professional team can assign 'tasks' to respective goals to indicate sequential milestones to goal attainment, due dates for task completion can be identified, priority of tasks can be identified, task comments are smart text enabled, task identification can then be linked to Therapy Assistant delegation.

Step 6. Clinicians can then finalize the Care Planning activity with the participants who are involved. Plans activity (Plan of Care) is a tool which allows clinicians to pull in what has been documented in Care Planning, designate participants (patient, family, friends, etc.), review with the participants for sign off.

Care Planning (Outpatient) and Collaborative Goals and Treatment Plan Flowsheet (Inpatient)

Care Planning

Do	Don't
• Use different language when talking about goals with clients' e.g. "What is it you want to do or be able to do that you can't right now?" or "Tell me about your past week. What went well? What was challenging?" • Ask clients about what is important to them and align your clinically indicated suggestions for tasks with what motivates them e.g. "These hand strengthening exercises will help you to crochet again." • Agree as a team on a process for who will initiate the treatment plans and how goals and tasks will be documented and updated.	• Don't use time as an excuse to not have goal setting conversations. Taking a little bit of extra time up front can save days and weeks of time without making progress. • Don't assume that professionals will all use the tools the same way without setting some expectations prior to launch. • Don't put your clinician goals in this tool. Find out what the patient's goals are and then add your clinician recommended tasks where appropriate to help the client achieve their goal. o No patient has ever said "My goal is to do 20 squats daily." but they have said "I want to be able hike to the tea house at Lake Louise this summer." and being able to do 20 squats daily will build their strength for hiking.