Patient-Aware Documentation Norms (Prescribers) - DRAFT

Norms

The Connect Care clinical information system (CIS) serves all who provide care where Connect Care is the record of care. Documentation Norms are about how Connect Care 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.

Trends

Clear, concise, and consistent documentation reflects good clinicianship — and warrants the same commitment to professional development as any other clinical skill. Although the core purpose of clinical documentation remains unchanged, the context in which it is created and reviewed has changed dramatically.

Documentation that functions well within a clinical information system differs significantly from what works for paper records. As Connect Care advances along its OpenNotes pathway, clinicians must refine their skills in patient-aware documentation to better recognize patients as a primary, not exceptional, audience for shared summative notes.

Applicability

Connect Care Documentation Norms apply to all Clinicians who generate documentation through direct entry, voice recognition, partial dictation or full dictation, anywhere and anytime across the care continuum. While relevant to all health care Providers, the norms carry specific expectations for Prescribers. The norms complement but do not replace AHS policy, directives and procedures relating to documentation.

Patient-aware clinical documentation is consistent with effective clinical communication. While clinical descriptors should remain complete and frank, clinicians can be mindful of wording that could trigger trauma for patient readers. Doing this promotes safe documentation for all.

Relevance

Historically, clinical documentation has presumed prescriber-to-prescriber communication. Indeed, in the case of most consultations, letter templates formalize both author (from) and intended recipient (to). This can lead to a (false) sense of exclusive communication.

Connect Care summative documents are shared with the provincial health information exchange (Netcare) as well as community electronic medical records (EMRs). In addition, prescribers can choose to share directly with the patient through Connect Care's patient portal (MyChart). Increasingly, summative documents will be shared by default, with prescribers able to over-ride sharing when clinically indicated.

Unfortunately, the language of clinical documentation has deep roots in medical history, attitudes and jargon… creating linguistic fences to keep clinical dialog exclusive. Evolving to more inclusive communication will take time, and effort.

The advent of default patient-sharing merits a "universal precautions" approach to document authoring. Prescribers should hone skills for patient-aware documentation and apply these consistently. The following guides can support development of patient-aware documentation skills.

Patient Aware Documentation Guides

Patient-aware clinical documentation should:

Use first-person language	by referring to patients as individuals with clinical conditions, rather than as members of a disease-cohort.
Respect patient identity preferences	by using word choices and documentation tools (e.g., pronoun SmartLinks) that reflect express patient preferences for name, pronouns, honorifics, relationship status, social or occupational roles, cultural or racial factors, and gender designations.
Avoid abbreviations and acronyms	by substituting full names and common language for all forms of medical shorthand.
Reflect the clinical encounter	by focusing on what was said, done and advised during the clinical interaction being documented.
Verify past history	by validating with the patient (and/or designate) medical, surgical and family history information derived from past or external sources.
Avoid bias or judgment	by using neutral words like “says”, “reports”, “did not tolerate” instead of clinical vernacular like “complains”, “endorses” or “refuses”.
Describe signs objectively	by using objective descriptions of a patient’s clinical appearance instead of subjective terms like “disheveled“, “older than stated age”, “pleasant” or “delightful”.
Make plans actionable	by listing clear next steps consistent with endorsed patient goals.
Quantify sensitive topics	by avoiding qualitative descriptors of sensitive observations, including substance use (quantify “use” of substances and exposures in preference to terms like “abuse”), sexual, employment and mental health history.
Take ownership	by use of “I” or “we” to signify the source of an assessment and plan (or, appropriately attribute to others, such as consultants), while also acknowledging temporal attachments (e.g., “at this time”) to allow for subsequent developments.

Patient-Aware Documentation Skills and Tools

Different CIS tools support different documentation needs. Preferred pronouns, for example, can be consistently applied by using SmartLinks to pull dynamic patient-centred data into documentation.

Each of the following sections highlight specific skills and tools that can support implementation of the above guides.

In general, use of provincial documentation templates will ensure that the core structure of a summative document reflects patient-aware best practices.

Use First-Person Language

What is it?

Why does it matter?

How is it done?

Do	Use First-Person Language	Don't
•		•

Respect Patient Preferences

What is it?

Why does it matter?

How is it done?

Do	Respect Patient Preferences	Don't
•		•

Avoid Abbreviations and Acronyms

What is it?

Why does it matter?

How is it done?

Do	Avoid Abbreviations and Acronyms	Don't
•		•

Reflect the Clinical Encounter

What is it?

Why does it matter?

How is it done?

Do	Reflect the Clinical Encounter	Don't
•	•	

Verify Past History

What is it?

Why does it matter?

How is it done?

Do	Verify Past History	Don't
•	•	

Describe Signs Objectively

What is it?

Why does it matter?

How is it done?

Do	Describe Signs Objectively	Don't
•	•	

Make Plans Actionable

What is it?

Why does it matter?

How is it done?

Do	Make Plans Actionable	Don't
•	•	

Quantify Sensitive Topics

What is it?

Why does it matter?

How is it done?

Do	Quantify Sensitive Topics	Don't
•	•	

Take Ownership

What is it?

Why does it matter?

How is it done?

Do	Take Ownership	Don't
•	•	