Connect Care

clinical information system

DOCUMENTATION

Norms

Alberta Health Services

Connect Care

Documentation Norms (Prescribers)

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.

Documentation Norms complement Minimum Use Norms. Both highlight the importance of collaborative, care-centric, comprehensive, current, credible, credited, curated and chronicled documentation.

The Clinical Information Sharing Approach (CISA) and Information Sharing Compact inform both Minimum Use and Documentation Norms by affirming expectations and accountabilities between Alberta Health Services (AHS) and Connect Care users, including responsibility for the completeness and quality of the health record.

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.

Goal

Connect Care clinical documentation will be:

1) Collaborative

with all health care providers sharing 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

with timely entries that allow the entire health care team to align with current plans.

4) Current

with timely entries that allow 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

Concisely balancing new observations with refinement 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. Health problem documentation, for example, is facilitated by a Problem List activity.

Each of the following activities is facilitated by a specific CIS tool or activity and workflow. The location of activities within CIS navigators, express lanes or other user-interfaces may vary in different clinical contexts (e.g., emergency, critical care, inpatient, outpatient, etc.). 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 Documentation Norms relate to each of the following types of documentation activities, further described in the sections that follow.

Health Problem Documentation

What is it?

The Connect Care CIS list of active health conditions (“Problem List”) appears in all charts in all contexts. It lists diseases, disorders, injuries and health conditions that have an impact on, or could be impacted by, a patient’s current care.

Health problems identified in the Problem List are standardized labels for conditions, diagnoses or risks. They map to codified terminology. Accordingly, when a health problem is referred to in the Connect Care CIS, it refers to a specific medical condition.

Why does it matter?

The Problem List helps clinicians identify and manage patients’ 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 the CIS, and beyond through patient and provider portals.

Who is responsible?

All Prescribers share responsibility to update and manage Health Problems, 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 (e.g., inpatient, outpatient), specialty, accountability and training. Connect Care does not micro-manage Problem List editing rights, instead expecting professionals to contribute responsibly while knowing that all entries and edits are tracked.

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” versus “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 health problem, or when consolidating a number of problems into one unifying diagnosis, it is important to help other Prescribers recognize changes and appreciate the reason(s) for changes

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).

Health Problem Documentation

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 Past Medical History or Past Surgical History.

Specific: The condition or diagnosis should be as specific as possible.

Category	Appropriate Problem List Entries	Example
• Chronic medical problems requiring ongoing therapy or surveillance.		• Asthma, Hypertension, Chronic Kidney Disease
• Recurring acute medical problems or conditions subject to exacerbations.		• Recurrent urinary tract infections, Recurring shoulder dislocation
• Problems requiring continuing or recurring prescription medical therapy.		• Migraine headaches, Sciatica, Anxiety
• Problems requiring continuing investigation or monitoring.		• Thrombosis for which anti-coagulation therapy continues.
• Acute problems while under active management.		• Abdominal pain, Headache, Low Back Pain
• Ongoing dependency or abuse		• Alcohol dependence, Opiate dependence
• Chronic psychiatric disorder		• Depression, PTSD, 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 Problem List by highlighting issues specific to the current encounter. Problem List entries are reviewed at admission to mark those that are a focus of care during the admission. These hospital problems are reviewed at discharge to determine which are resolved and which need to remain in the enduring 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.

The inpatient Problem List area (charting activity) may additionally include a section for 'Multidisciplinary' issues abstracted from care plans or other care coordination tools. These are distinct from health problems and are usually non-medical diagnoses managed by members of the patient's care team. Listed issues may include symptoms (e.g., pain, nausea, etc.), nutritional status, functional status or goals pertinent to a specific encounter. Multidisciplinary issues are not edited by Prescribers, do not appear on the Problem List, and are not included in this Problem Documentation Norm.

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 Medical or Surgical 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.

Appropriate past medical history entries might include resolved chronic conditions, like obesity, but not temporary problems like conjunctivitis or intermittent symptoms like dry eyes

Health Problem Documentation

Problem List Management

Do	Health Problem Documentation	Don't

- 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 lessor 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.

- Duplicate: Add a new problem when a less specific existing problem could be revised.
- Butt-in: Delete or override active problems, overviews or comments if you are not the Prescriber managing the problem.
- Clutter: Add diagnoses that are self-limited or do not require active management with diagnostic, therapeutic, rehabilitative or palliative interventions.
- Destroy: 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 documentation is about how responsible Prescribers indicate the most responsible reason for the health encounter or the conclusion reached as a result of the encounter.

Diagnosis documentation applies in all health contexts across the continuum of care (inpatient, outpatient, emergency, continuing, etc.). 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 as yet not associated with an underlying cause. Irrespective, the encounter diagnosis is recorded using standardized medical terminology and is codified for reporting purposes.

Why does it matter?

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

All members of the care team rely on clear, precise and codifiable 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 those most like them. Opportunities for personalized and precision medicine depend upon accurate encounter diagnoses in the context of comprehensive Problem Lists.

Who is responsible?

Prescribers are typically responsible for the selection and recording of a most responsible diagnosis. Other clinicians may independently record discipline-specific reasons for non-Prescriber health encounters.

How is it done?

All outpatient encounter navigators include a section for "Visit Diagnoses," where preference lists allow easy selection of common diagnoses. Any Problem List element can be selected as an encounter diagnosis.

Inpatient encounters end with discharge, transfer or death. All inpatient encounter summaries call for a most-responsible diagnosis and, optionally, other health problems that significantly contributed to the admission or course in hospital.

Do	**Diagnosis Documentation**	Don't
• Specify one primary visit diagnosis (outpatient) or most responsible discharge, transfer or death diagnosis (inpatient). • Promote final diagnosis from the Problem List as part of final Problem List reconciliation.		• 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-centred 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 collaboration to optimize safe, effective and appropriate drug therapies.
Best Possible Medication History (BPMH)	Complete and accurate list of all of the medications a patient is taking, created using at least two information sources that include a patient or proxy interview.
Medication Reconciliation	Formal process in which healthcare Prescribers 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.

Reconciliation uses a BPMH to establish what a patient should be taking, and actually is taking, then clarifies changes, adjustments or discontinuations associated with the start or end of an episode of care. It also includes re-consideration of pre-encounter medications at the conclusion of the episode.

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 misadventure. 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 members of a multidisciplinary health care team can contribute to medication management. Roles, scopes of 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 is typically a Prescriber responsibility. Inpatient reconciliation is done by the admitting Prescriber(s). Prescribers are responsible for medications of their own ordering but must also consider effects of other Prescribers' actions and ensure that subsequent Prescribers are supported with all the information needed to refill, prescribe and de-prescribe safely.

Do — Medication Documentation — 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), pharmacist prescribed, alternative, hormonal, illicit and scheduled substances.
- Record source(s) of medication information during best possible medication history, medication review and medication reconciliation activities.
- Disclose clinically pertinent reasons for medication discontinuation, dose adjustments, substitutions or new prescriptions.
- Clarify the intended duration of any medication holds.
- Take the opportunity of medication reviews to de-prescribe medications no longer needed.

- Rely exclusively on past discharge or consultation medication lists, or drug dispensing records (e.g., Pharmacy Information Network, PIN in Netcare EHR).
- Prescribe new medications without confident knowledge of all current and planned medications.
- Continue medications for which there are no clear indications.
- Continue medications with possible harmful effects unless adverse event monitoring is in place.
- Let medication reconciliation slip from essential clinical service to resented administrative hassle.
- De-couple medication and adverse reaction surveillance.
- Use comment boxes to specify prescriptions when there are discrete data fields available to capture form, route, dose and frequency of use

Adverse Reaction Documentation

What is it?

Ensuring documentation of a patient's adverse reactions to medication, immunization, dietary, 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 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 this information, reaction lists clarify, alerts are usually meaningful, and the time required of any one clinician to find or review reactions decreases.

Consistent use of standardized descriptors ensures that decision supports (e.g., alerts, reminders) have few false positives and negatives. Consistency also facilitates quick review, finding 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, who characterize the type, severity and confidence of a reaction. Prescribers are responsible for learning how to use standardized descriptors when checking the completeness, precision and accuracy of reaction reports. These clinicians are also responsible, as a matter 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 done in the "allergy/contraindications" activity which can be accessed through the Patient Storyboard in all CIS contexts. Serious adverse drug reactions must be supplemented with an online Adverse Drug Reaction Report when first documented.

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. • Pull in (rather than re-enter) Adverse Reactions to external communications, using smart tools (e.g., SmartPhrase) when needed.	• Include known common side effects of medications unless important to warn future Prescribers to consider particular sensitivities. • Use tools other than the allergy/contraindications activity or the linked adverse drug reaction flowsheet to document Adverse Reactions. • Repeat adverse reaction data in notes unless it is essential to record the state of reactions at a specific point in time

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:

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. Progress notes are typical transactional documents. Ideally, they highlight clinically important developments since the last summative note.

2. Summative documentation gathers all information pertinent to an encounter or episode, organizes observations, exposes meaning, and offers a plan keyed to care goals. Examples of summative documents include consultation notes, admission histories, discharge summaries, surgery reports, transfer notes and integrative plans of care.

Best practices vary by category.

Why does it matter?

The Connect Care health record will capture massive amounts of information, especially for patients suffering from chronic health problems. Good clinical documentation increases the ‘signal’ to ‘noise’ ratio, decreasing the chance that important information will be missed.

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 appreciated. Well-structured notes are easier to find, filter, scan and trend.

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

Clinical Documentation

Who is responsible?

All health care providers have documentation management responsibilities. These may be primary, where the clinician is entirely accountable for what (s)he records. They may also be secondary, where the Prescriber oversees trainees, learners or scribes. Clinical Documentation Norms apply whether one is an original author, editor or consumer of documentation started by others.

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

How is it done?

Good clinical documentation is concise and unique. This is difficult in paper-based systems, where notes may need to replicate information spread across many volumes. A well-organized electronic record, by contrast, allows brevity because related information can be referenced and linked. Clinical notes can be interpretive, focusing on the meaning of data organized in appropriate sections of the record.

Minimizing inappropriate duplication reduces information burdens for both producers and consumers of notes. Information gathered by any member of the multidisciplinary team can be cross-referenced. Duplicative discipline-based documentation silos are discouraged.

Copy-Paste

Copy-paste practices can save documentation entry time in the short term but increase documentation review time in the long term. Used imprudently, 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. It is always better to reference original content and highlight changes occurring since. Any copy-out (copy from Connect Care CIS to a separate information system) must be done with extreme caution, as there is risk of a privacy breach.

CIS users who copy-paste for convenience (e.g., 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, acknowledging the original context in which the copied information was generated. Clinicians are responsible for clearly identifying who performed any interventions documented. They must also preserve properties (e.g., importance or criticality markers) and protections (e.g. break-the-glass or masking) of sensitive copied material.

Clinical Documentation

Progress Documentation

When documenting multiple times during an extended 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.

Progress Documentation

Do	Don't
• Be concise, avoiding information readily available in standard chart sections. • Standardize progress and procedure note formatting by using provided note types with standardized subheadings (e.g., SOAP), using 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, highlighting trends, significant developments, and specific outcome markers. • Where documentation by exception is appropriate, summarize lack of change with indicators like "no adverse change" or "within normal limits".	• Re-enter patient-level (e.g., problems, history) or encounter-level (e.g., 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. • Routinely pull in data (e.g., vitals, labs) readily available elsewhere unless directly relevant to decisions made during the event documented. • Use text automations that imply observations that were not completed. • Repeat investigation data when interpretive comments suffice (e.g., "yesterday's laboratory results were as expected, with the exception of…"). • Modify, replicate or delete documentation of another user that was not intended for shared editing.

Clinical Documentation

Summative Documentation

Summative documentation serves consultation, admission or transfer by generating a note that can stand on its own. It may be the basis for a communication sent to a referring or responsible Prescriber. Comprehensiveness is favoured over efficiency.

It is important for summative documentation to bring together material from 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.

It is essential for summative documentation to be standardized whenever possible. Discharge Summaries, for example, need to have consistent sections in a consistent order. This greatly facilitates communication with the many care team members who work where Connect Care is not the record of care. Any admission, discharge, transfer, deceased or consultation documentation should use Connect Care standardized template(s).

Do	**Summative Documentation**	Don't
• Use text automations (SmartPhrase, SmartText, etc.) to pull information into the summary, 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 opportunity to curate, correct and update transactional documentation. • Use standardized templates, navigators and/or activities for common summative documentation (e.g., admission, discharge, transfer, consult).		• Use communication tools (e.g. letter, fax) for summative documentation when a chart note could suffice and be pulled into the communication tool. • Create summative documents outside the CIS, expecting to attach these communications to the chart. • Pull in excessive chart information if the summative documentation stays within the Connect Care CIS and is not intended for external sharing. • Incorporate the summation or analysis of others without attribution.

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 encounter properties which, in turn, affects what other Connect Care 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 Prescriber, 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 health care Prescriber designated as the responsible Prescriber 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.

The encounter team must work together. If multiple disciplines initiate notes in an encounter, and just one of the health care professionals has an incomplete note, the encounter cannot be closed until that note is signed or set for “Sign at Close Encounter”.

Encounter Documentation

How is it done?

An encounter is ‘closed’ when the responsible Prescriber completes and ‘signs’ essential tasks, such as note and order-entry, then selects a prominently displayed ‘Close Encounter’ button.

A section of the Prescriber’s In-Basket lists all encounters that remain in an open state.

Encounters do not have to have all questions answered or all results available in order 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.

Do	Encounter Documentation	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.		• Defer signing encounters simply because test results are awaited.