CancerCare Manitoba
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GOVERNING DOCUMENTS

Policy and Procedure

Title:	**Entries Into CCMB Health Records**
Policy Number:	06.025
Effective Date:	January 9, 2015
Revised Date:	March 14, 2019
Approving Body:	President and CEO
Authority:	CancerCare Manitoba Act
Responsible Officer:	President and CEO
Delegate:	Director, Cancer Clinical Information Management and Privacy Officer
Contact:	Cancer Clinical Information Management and CCMB Privacy Officer
Applicable to:	CCMB Staff and Physicians

1.0 **BACKGROUND:**
Not Applicable

2.0 **PURPOSE:**

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

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

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

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

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

3.0 **DEFINITIONS:**

3.1 **Agency Staff:** a category of individuals who are not employed by CCMB facilities or CCMB-funded facilities but who fit the classifications under legislated health professionals, non-legislated health professionals or support staff and are contracted by CCMB or CCMB-funded facilities to provide health care and to make entries into the facility health record.

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

3.3 **CCMB Initials Verification Record:** an approved health record form which is designed to collect and display samples of health care provider's full signatures along with their initials and printed name.

3.4 **Computerized Provider order Entry (CPOE) System:** an electronic method for use by authorized clinicians to transmit clinical orders entered into the electronic

oncology record (EOR) to the appropriate department for direct or indirect processing. The orders will be listed in the EOR with indications of what has been completed and what is pending. Electronic alerts will appear for specified order duplications and to provide information to assist clinical decision-making.

3.5 **Electronic Record:** for the purposes of this policy means the electronic oncology record (EOR) or the electronic medical record (EMR).

3.6 **Entries into the Facility Health Record:** a notation recorded for each medication, treatment, assessment, procedure, investigation, phone call or situation pertaining to a patient; including health care provided to, or on behalf of the patient as well as the patient's response to the health care provided.

3.7 **Finalized Electronic Entry:** also known as a locked electronic entry, means a saved version of an entry into an electronic record which requires special actions such as a correction, amendment, addendum or late entry to modify the recorded information.

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

3.9 **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 facility health record.

3.10 **Legislated Health Professionals:** staff 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.

3.11 **Non-CCMB Agencies:** entities which are not owned or operated by CCMB that are contracted to supply agency staff to CCMB or CCMB-funded facilities. Examples of non-CCMB Agencies are staffing agencies that supply nursing personnel.

3.12 **Non-Legislated Health Professionals:** staff who does 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 the facility health record.

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

3.13.1 **Fax Orders:** those written and authenticated by a legislated health professional who gave the order which are transmitted by a facsimile machine to the location where care is being provided.

3.13.2 **Protocol Orders:** any evidence-informed practice tool (care maps, clinical protocols, clinical practice guidelines, clinical algorithms), standing orders and standard orders.

3.13.3 **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.

3.13.4 **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.

3.13.5 **Written Orders:** those entered and authenticated in the health record by a legislated health professional who is giving the order.

3.14 **Other Personnel:** non-CCMB Staff who do not fit the definitions of a legislated health professional, a non-legislated health professional, support staff, agency staff, non-CCMB personnel, or students but who have a role in the patient's health care and are authorized to make entries into the health record.

3.15 **Patient:** any individual receiving health care provided by CCMB, regardless of whether they are referred to as a patient, client or resident.

3.16 **Provider of Record:** a member of CCMB medical staff with attending privileges whose name has been entered in the Health Record as the individual with overarching responsibility for the care of a Patient at CCMB sites or programs.

3.17 **Staff:** individuals employed by CCMB sites or programs, as well as members of CCMB medical staff.

3.18 **Student:** individual from a learning institution with a contract for student placement within CCMB sites or programs.

3.19 **Substitute Decision Makers:** a third party identified to participate in decision-making on behalf of a patient whom lacks decision-making capacity, concerning a proposed procedure, treatment, or investigation.

3.20 **Support Staff:** staff included in the listing under category #2 of **Categories of Persons/Classifications Authorized to Make Entries into the Health Record** *(See Appendix 1).* These staff do not fit the definition of a legislated health professional or non-legislated health professional but have a role in providing health care.

3.21 **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 timeframe to make it a finalized electronic entry.

4.0 **POLICY:**

4.1 Individuals listed in the **Categories of Persons/Classifications Authorized to Make Entries into the Health Record** (Appendix 1), are authorized to make entries into the health record and shall review the health record as appropriate, make entries to reflect their scope of practice, role and involvement with care, treatment and services which are planned for and provided to the patient.

4.2 The health record is the primary communication tool of health care providers who shall make entries into health records 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 patients such as printouts of email communications between health care providers are not acceptable replacements for concurrent and direct documentation into the health record and shall not be filed or retained on the health records.

4.3 Entries into the health record shall be appropriate, accurate, complete and timely. All persons authorized to make entries into the CCMB health record shall:

4.3.1 Adhere to all legal requirements and ethical expectations for documentation set forth by provincial legislation, professional governing bodies, regulatory bodies, CCMB or CCMB-funded facilities' policies and guidelines.

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

4.3.3 Document in a manner that coincides with *CCMB's Corporate Respectful Workplace Policy 01.005.*

4.3.4 Document according to the charting methodology or system adopted by the facility, site, program or discipline; for example, SOAP where S stands for Subjective, O stands for Objective, A stands for Assessment, and P stands for Plan.

4.3.5 Make entries concurrent with health care provided and include the date and time for each entry made. The date shall be written or displayed as two numeric characters for the day, three alpha characters for the month and four numeric characters for the year; e.g. 31/Mar/2012. The time shall be written or displayed in the 24-hour clock; e.g. 1315 hours.

4.3.6 Include the date and time a late entry was recorded along with the date and time that the health care event occurred.

- A late entry to a structured note; for example an integrated progress note, in the electronic record shall be 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)/visit 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.

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

4.3.8 Comply with *CCMB's Policy for Medication Order Writing Standards 3.20.245* on the use of abbreviations, acronyms and symbols.

4.4 Orders entered in the health record including verbal orders, telephone orders, protocol orders, fax orders and written orders shall conform to the following principles:

4.4.1 All legislated health professionals shall be granted order-writing authority. What is ordered by each legislated health professional shall be determined by the clinical program/designate responsible for the standard of care provided to the patient and shall stipulate those orders:

4.4.1.1 That require the approval by the provider of record prior to implementation;

4.4.1.2 That do not require approval by the provider of record prior to implementation. In making these determinations and requirements, the clinical program/designator's decisions shall be guided by the scope of practice of the legislated health professional and shall be consistent with that professional's role on the specific health care team.

4.4.2 Legislated health professionals shall be accountable for each telephone or verbal order they give or receive from another legislated health professional.

4.4.3 All telephone and verbal orders shall be co-signed by the legislated health professional who gave the order.

4.4.4 In facilities where Computerized Provider Order Entry (CPOE) is available, all authorized prescribing providers within their discipline and facility approved scope of practice shall enter patient orders in the electronic

oncology record (EOR) unless there is an approved exception. All care providers shall receive access to CPOE functionality following successful completion of the EOR training for CPOE and shall comply with all existing policies and procedures.

4.4.5 Legislated Health Professionals in student roles shall 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 shall indicate this on the Order Sheet. For example, a medical student would document: "Discussed with Dr.____." A legislated health professional shall countersign all non-medication orders written by Students within 24 hours.

4.4.6 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 shall be referred to provider of record by one or both parties with a request for resolution.

4.5 Requests by a Patient or their personal representative for corrections of entries in the health record shall follow established procedures set forth in the CCMB Policy Correction of Personal Health Information, 06.002.

5.0 **PROCEDURE:**

5.1 Individuals authorized to make entries into the facility health record shall ensure that entries:

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

5.1.2 Include the date and time and are:

5.1.2.1 Made in chronological order at the time the event or observation took place or as soon as possible thereafter;

5.1.2.2 Not made in advance of the time of the event or observation; and

5.1.2.3 When applicable, identified as a "Late Entry" and indicate the date and time the entry is being made and within the body of the note indicate the date and time of the event or observation.

5.1.3 Are authenticated by their handwritten signature or an electronic signature. The signature shall include the initial or full first name and surname of the person making the entry along with their professional designation. Initials may be used in place of full signatures at facilities using Signature and

Initial Verification Records provided 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.

5.2 Legislated health professionals receiving a telephone order or a verbal order shall:

5.2.1 Repeat the order to the legislated health professional who gave it. The legislated health professional shall confirm back to the receiver that the order they gave has been heard correctly.

5.2.2 Enter the order on the order sheet or into the computerized provider order entry system clearly indicating the source of the order (i.e. telephone order or verbal order and the name of the legislated health professional that gave the order).

5.3 All entries into the paper-based health record, including signatures and printed names shall be written or printed legibly using a ballpoint pen with permanent black, blue or red ink. Gel pens, non-permanent marker, erasable ink and pencil shall not be used.

5.4 Corrections made to paper-based entries into the facility health record, shall be made by:

5.4.1 Placing brackets around the incorrect entry and also drawing a line through the entry ensuring that the inaccurate information is still legible. Do not obliterate the original entry with marker, whiteout, and correction tape or by writing over the entry.

5.4.2 Writing “error” on top of the incorrect entry and initialing and dating the entry.

5.4.3 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.

5.5 Corrections made to electronic-based entries into the health record, shall be made by:

5.5.1 Appending a note to a finalized electronic entry.

5.5.2 Adding, correcting or removing information from an unfinalized electronic entry.

5.6 Corrections to paper-based entries into the health record which have been entered in the wrong Health Record shall be as follows:

5.6.1 The entry in the wrong health record shall follow procedures established in 5.4. The individual making the correction shall flag the health record in a way that alerts other staff to remove the information when responding to a disclosure or access request.

5.6.2 The information entered 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.

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

5.7.1 An entry in the wrong health record shall be cancelled with a cancellation reason indicated.

5.7.2 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.

5.7.3 The information is entered in the correct health record according to policy.

5.7.4 Documentation with a cancelled documentation status will not be included in response to a disclosure or access request.

5.8 Corrections to orders in electronic records which have been entered in the wrong health record shall be made as follows:

5.8.1 An order entered in the wrong health record shall be discontinued with a discontinuation reason noted.

5.8.2 Documentation elsewhere in the health record that is impacted by the wrong entry shall be identified and deleted and an addendum entered to explain the situation.

5.8.3 The information is then entered in the correct health record according to policy.

5.8.4 Documentation with a discontinued documentation status will not be included in response to a disclosure or access request.

5.9 Legislated health professionals, non-legislated health professionals, support staff and any others not identified in the **Persons/Classifications Authorized to Make Entries into the Health Record** *(See Appendix 1)*, shall bring a request and supporting justification to make entries into the health record, to the attention of the Cancer Clinical Information Management Manager within CCMB or their designate.

5.9.1 The authorized person shall consider the requests using defined CCMB processes and make a decision to approve (or reject) the request and notify the requestor of the outcome.

5.9.2 Changes to Appendix 1 will be addressed through CCMB policy review processes.

6.0 **REFERENCES:**

6.1 WRHA Entries into Facility Health Records, Policy 75.00.060.

6.2 American Health Information Management Association (AHIMA). Making Corrections in the HER, Webinar March 11, 2010.

6.3 Fletcher, Donna M. "Best Practices in Medical Record Documentation and Completion", *Journal of AHIMA*, retrieved 2/17/2007 from http://library.ahima.org.

6.4 The College of Physician's and Surgeons of Manitoba, Guideline No: 104 Medical Computer Systems: Security and Self-Audit; PR/05-90, Revision PR/05-98.

6.5 The College of Physician's and Surgeons of Manitoba, Guidelines No: 117, The Physician Medical Record, 4th L & E/08-93, Revision Council/03-08.

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

6.7 CCMB Respectful Workplace, Policy 01.005.

6.8 CCMB Correction of Personal Health Information, Policy 06.002.

6.9 CCMB Medication Order Writing Standards, Policy 3.20.245.

Policy Contact: All enquiries relating to this policy should be directed to:	
Name:	
Title/Position:	Director, Cancer Clinical Information Management and Privacy Officer
Phone:	204-792-2535
E-mail:	
Address: (if required):	

DOCUMENTATION	
Policy Location: This policy is located (hard and e-copy formats):	
1.	The original signed and approved policy is on file in the Executive Office, CCMB
2.	The e-copy is on file in the CCMB Governing Documents Library, SharePoint
3.	

Revision History:

Date	Version	Status	Author	Summary of Changes
dd/mm/yyyy	#	Initial, Draft Final Minor/Major revision		
30/09/2014	1	Initial	Health Records Policy Team	New CCMB policy in alignment with WRHA policy.
09/01/2015	2	Minor revision	Policy Team	Final review prior to approval.
29/03/2018	2	Minor revision	S.Friedenberger	Reformatted to new template
14/03/2019	3	Minor revision	C. Slusky	Change to Director and Dept. Name

Approvals Record:
This Policy requires approval by:

Approval		
Date	**Name / Title**	**Signature**
	Not required.	

FINAL APPROVAL:

Date	**Name / Title**	**Signature**
14/03/2019	Dr. S. Navaratnam President and CEO, CCMB	*Original signed by* *Dr. S. Navaratnam*

APPENDIX A

Persons/Classifications Authorized to Make Entries into the CCMB Health Record

CATEGORY #1: LEGISLATED HEALTH PROFESSIONALS (in alphabetical order)	
Allied Health	**Medical Staff**
Audiologists	Clinical Assistants or Physician Assistants
Dental Hygienists	Dentists and Oral Surgeons
Occupational Therapists	Midwives
Optometrists	Physicians
Pharmacists	Psychologists
Physiotherapists	Trainees (Clinical Clerks, Residents, Fellows)
Podiatrists	
Registered Dietitians	**Nurses**
Respiratory Therapists	Graduate Nurses
Social Workers*	Licensed Practical Nurses
Speech Language Pathologists	Registered Nurses
**Pending enactment of Social work Professions Act (granted royal assent October 8, 2009)*	Registered Nurses(Extended Practice) Nurse Practitioners
	Registered Psychiatric Nurses Clinical Resource Nurse (CRN)

CATEGORY #2: NON-LEGISLATED HEALTH PROFESSIONALS AND SUPPORT STAFF (in alphabetical order)	
Aboriginal Services Workers	Outreach Worker
Assistive Technology Coordinator	Patient Representative/Relations Officer
Cardiology Technologists	Pharmacy Technicians
Child Life Librarian	Physiotherapy Assistant/Aides
Child Life Specialists	Prosthetists
Dialysis Care Technicians	Radiation Therapists
Dietetic Technicians Ethicists	Recreation Coordinators/Facilitators Rehabilitation Assistants/Attendants (includes
Families First Home Visitor	Communication Disorders Assistant)
Genetic Counselors	Rehabilitation Clerks
Health Care Aides	Rehabilitation Design Engineers - Special
Hearing Screener	Devices
Home Care Attendants	Rehabilitation Electronic Technicians
Immunization Clerks	Rehabilitation Engineers
Infection Control Practitioner/Professional	Rehabilitation Electronic Specialists
Medical Laboratory Technologists	Rehabilitation Machinists
Medical Radiation Technologists	Rehabilitation Mechanical Specialist
Mental Health Workers (i.e. Proctors)	Respiratory Therapy Assistants

…continued

APPENDIX A - *continued*

(MRI) Magnetic Resonance Imaging Technologists	Orthotists
Nuclear Medicine Technologists	Sonographers Spiritual Care Providers
Occupational Therapy Assistants/Aides	Therapists: Athletic, Music, Recreation
Occupational Therapy Technicians	Unit Assistants
Orthopedic Technicians & Technologists	Unit Clerks

CATEGORY #3 AGENCY STAFF:

Staff who are not CCMB employees but who are contracted from agencies that supply health care staff falling into the disciplines listed in the Legislated Health Professional category or the Non-Legislated Health Professionals and Support Staff category.

CATEGORY #4 PRIVATELY HIRED CARE PROVIDER:

An individual who fits the definition of Legislated Health Professionals but who is not an employee or agent of CCMB and who is retained by the patient, family, substitute decision maker or third party funder to provide health care.

CATEGORY #5 STUDENTS:

Individuals from learning institutions which have with a contract for student placement with a facility, site or program of CCMB and who fall into disciplines reflected in the Legislated Health Professional category or the Non-Legislated Health Professionals and Support Staff category.

Students sign for their own entries and use the appropriate designation. Student entries are reviewed by educational facility staff or by staff on the clinical area and may be co-signed by professional staff supervising their placement.

CATEGORY #6 OTHER PERSONNEL:

Individuals who do not fit the definitions of Non-Legislated Health Care Professionals or Support Staff, Agency staff, Privately Hired Care Provider or Students; for example, Team Manager, Administrative Support Staff, Authorized Representative of Child Care Services as defined in the Manitoba Child and Family Services Act.