College of Respiratory Therapists of Alberta

Documentation Guidelines For Registered Respiratory Therapists

Key Assumption

This presentation complements, rather than replaces, your employer's documentation policies. Always prioritize your organization's specific guidelines. This information does not constitute legal advice; please consult a qualified lawyer for legal counsel.

The next two slides link the College Standards of Practice with the guidelines.

Introduction

Documentation is an essential component of respiratory therapy, critical for upholding safety and accountability standards across all practice environments. These requirements remain constant, regardless of whether documentation systems are paper-based or electronic.

Respiratory therapists are expected to adhere to all established employer policies and guidelines. In the absence of specific employer-provided policies, practitioners should rely on these guidelines and their own professional judgment to direct their practice.

Applicable Standards of Practice

3. Be accountable for their professional practice.

3.4. Appropriately document, on paper and/or electronic form, all information regarding initial assessments, patient response to therapeutic interventions and follow-up and discharge plans. The registrant ensures that all documentation is legible, comprehensive, concise, and pertinent. The registrant notes the date and time of each chart entry and affixes their protected title or initials on all documentation. The registrant co-signs entries into the patient/client care record made by students.

Applicable Standards of Practice continued

8. Evaluation of Competency
8.2. Document the outcome of witnessing the clinical evaluation.

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12. Appropriateness of virtual care when providing a professional service.
12.8. A regulated member who provides virtual care must document in the patient record
12.8.1. the informed consent of the patient to receive virtual care;
12.8.2. the time, date, and enabling technology used to provide virtual care in the patient's record; and
12.8.3. the requirements outlined in standard 12.8.

Characteristics of Good Documentation

Documentation shall provide an accurate and honest account of what and when events occurred including the identity of the caregiver.

The characteristics of good documentation include:

- factual
- accurate
- complete
- current
- organized
- conforms with employer policies and College standards.

Factual

- A factual record contains descriptive objective information about what the respiratory therapist sees, hears, feels and smells.
- Objective description results from direct observation and measurement ie. SPO2 – 93%, Heart rate – 88 beats per minute, respiratory rate – 24 breaths per minute.
- Inferences (i.e. shortness of breath) should be avoided unless there is supporting factual data.
- Avoid the use of vague terms like appears or seems because these may reflect your opinion and may be unsupported.
- When recording subjective data document patients exact wording wherever possible i.e. Patient states, "I feel short of breath".

Accurate

- Use exact measurements whenever possible.
- Avoid the use of unnecessary words and irrelevant details.
- If your institution has developed a list of approved abbreviations and acronyms follow their guidelines and policies.
- Avoid using dangerous abbreviations.
- Every entry must be dated (YYYY-MON-DD) and each entry should contain the caregivers name and status.
- Chart only your own actions and observations during the time of the entry. Your signature holds you accountable for the information in the entry.

Complete

- The information in a chart entry must be complete, containing all the essential information. All respiratory therapy interventions delivered to a patient must be documented including patient and family education.

Current

- Documentation should occur as soon as possible after the intervention.
- Care should be taken to keep events in chronological order.
- Employer policies will determine what a late entry is defined as and how to address this issue. A phrase like “Late entry for date and time” should be inserted immediately after the current date and time.

Conforms

- Your employer will have selected a method for charting. This method will reflect the philosophy of the department and incorporate standards of care.

Organized

- Many tools are commonly used to help the caregiver organize their charting.
- These tools include flowsheets, checklists, and protocols.
- Other helpful tools include formats like SOAP (Subjective, Objective, Assessment, Plan), FOCUS DARP (Data, Action, Response Plan) and PIE (problem-intervention-evaluation).
- Review your employer policies and utilize approved formats.

What is Health Information

- Health information is the data related to a person's medical history, including symptoms, diagnoses, procedures, and outcomes.
- Health information records include patient histories, laboratory results, x-rays, clinical information, and notes.

What is Health Information

- Health information also includes personal also called “registration information” as defined in the *Alberta Health Information Act4 (1)(u*) as:
  - “(u) “registration information” means information relating to an individual that falls within the following general categories and is more specifically described in the regulations:
    - (i) demographic information, including the individual’s personal health number;
    - (ii) location information;
    - (iii) telecommunications information;
    - (iv) residency information;
    - (vi) billing information,”

What is health information

The Alberta Health Information Act (1)(t) defines the health information record as:

- “(t) “record” means a record of health information in any form and includes notes, images, audiovisual recordings, x-rays, books, documents, maps, drawings, photographs, letters, vouchers and papers and any other information that is written, photographed, recorded or stored in any manner, but does not include software or any mechanism that produces records;”

Reasons (Purpose) for Documentation

- The patient record is both a medical and legal record used by all members of the health care team that describes the clinical status, care history and caregiver involvement.
- The specific information contained in the chart provides a record of a person's clinical condition by detailing diagnoses, treatments, tests and responses to treatment, as well as any other factors that may affect the person's health or clinical state.

Reasons (Purpose) for Documentation

The record can be used for:

- Communication and Care Planning;
- Legal Documentation;
- Education;
- Funding and Resource Management;
- Research and;
- Auditing Management.

Reasons (Purpose) for Documentation

Communication and Care Planning

Method by which team members communicate with each other about patient progress, therapies, education and discharge planning… The record is the most current and accurate source of information.

Legal Documentation

The legal purpose of documentation is to accurately and completely record the care given to patients as well as their response to that care. “if it is not charted then it was not done”. To limit liability clearly document individualized, goal directed respiratory care based on assessment was provided to your patient and that you continue to monitor progress.

Reasons (Purpose) for Documentation

Funding and Resource Management

Chart audits (especially electronic records) can be used to determine how resources are being utilized and the timing and reasons for caregiver/patient interactions.

Research

Clinical records can be used for research and to help determine if treatments are effective.

Auditing Management

The records can be used to evaluate the quality and appropriateness of care.

Documentation Methods

Documentation methods must align with client care needs and practice context, though employers may combine formats. Any changes to these methods require strategic planning that includes the involvement and education of respiratory therapists.

Regardless of the method used, respiratory therapists are responsible and accountable for documenting patient assessments, interventions carried out, and the impact of the interventions on outcomes.

Patients who are very ill, considered high risk, or have complex health problems generally require more comprehensive, in-depth and frequent documentation.

What Does It Mean to Co-sign/Countersign?

To "co-sign" means to agree with or concur with a student's entire chart entry. Registered respiratory therapists must co-sign student entries only for activities they personally witnessed.

When co-signing, specify the exact activity observed (e.g., confirming you were present and directly observed a student performing an arterial blood gas). This differs from a "countersignature," which serves solely as confirmation or authentication of a previously signed document.

CARTA Standards of Practice mandate that all respiratory therapy student chart entries be co-signed.

Electronic Health Record (EHR)

Technology enhances patient documentation while maintaining the core principles of data management used in traditional paper-based systems. An Electronic Health Record (EHR) is a secure, digital repository of a patient's comprehensive medical history. It facilitates real-time, shared access among authorized providers, improving care coordination and clinical decision-making.

Electronic Health Record continued

Electronic health records require documentation that is comprehensive, accurate, and timely, with clear identification of the care provider.

All entries must be made exclusively by the registered respiratory therapist who delivered the care, rather than by other staff members.

Once recorded, these entries constitute a permanent component of the health record and are strictly prohibited from deletion.

Electronic Health Record

When corrections are required after an entry has been stored, agency policies provide direction on the process. Employers using electronic documentation maintain policies covering the following areas:

- Correcting documentation errors or making “late entries”
- Identifying changes and updates to the record
- Maintaining system security (passwords, virus protection, encryption, firewalls)
- Backing up client information
- Documenting during system failures
- Preventing information deletion
- Protecting client confidentiality
- Tracking unauthorized access to client information
- Documenting in agencies using mixed electronic and paper systems