



TITLE

CLINICAL DOCUMENTATION

SCOPE

Provincial

DOCUMENT #

1173

APPROVAL AUTHORITY

Clinical Operations Executive Committee

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SPONSOR

Quality and Chief Medical Officer

REVISION EFFECTIVE DATE

Not applicable

PARENT DOCUMENT TITLE, TYPE AND NUMBER

Not applicable

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August 10, 2018

NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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OBJECTIVES

- To ensure **clinical documentation** within the Alberta Health Services' (AHS) **clinical record**, a subset of the **health record**, supports **health care providers** in the delivery of high-quality patient care, strengthens **patient** safety, and promotes continuity of care.
- To ensure clinical documentation practices promote the AHS *Patient First Strategy*, the *Collaborative Care Model*, and enables a quality health system that is accessible and sustainable for all Albertans.

PRINCIPLES

Alberta Health Services and all health care providers within the health system have legal, ethical, organizational and professional obligations (authority, responsibility, and accountability) related to the maintenance of clinical records. These obligations reflect how care is provided, facilitate communication among caregivers, and comply with the *Health Information Act* (HIA) [Alberta] and AHS bylaws, policies and procedures.

Clinical documentation is vital to the provision of high quality and safe **health service(s)** across the continuum of care. The clinical record is a critical component of collaborative care, patient and family-focused service, quality assurance and organizational learning.

Effective clinical documentation promotes the care of both individuals and populations, while contributing to the improvement of the health care system as a whole.

Clinical records must be reliable and accurate to enable “One Person. One Record. One System.”

APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, Students, Volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

ELEMENTS

1. Compliance

- 1.1 This Directive, and any associated documents, apply to all aspects of clinical documentation, including clinical documentation processes, the development and implementation of clinical documentation practices, and the production of charting guides and norms that support clinical documentation.
- 1.2 All individuals shall adhere to all applicable clinical documentation requirements contained in:
 - a) AHS policy;
 - b) professional practice standards;
 - c) ethical standards;
 - d) accreditation standards; and
 - e) legislation and regulations.

2. Clinical Documentation Principles

- 2.1 Clinical documentation shall:
 - a) support the practice of patient and family-centred care by promoting respect & dignity, information sharing, patient participation, honouring choices, and collaboration in influencing how health services are provided;
 - b) be patient-centred, meaning accessible to patients (through approved channels) and attentive to patients' goals, perspectives and choices;
 - c) support patient care and the professional practice process;
 - d) accommodate minimum data sets, standardized terminologies, and standardized tools where these best support clinical processes and outcomes;
 - e) be accurate, complete, clear, concise, legible, timely, and ordered to enable the health care provider to:

- (i) record the patient's perspective on their health care needs, goals, and preferences;
 - (ii) access the needed information to make informed clinical decisions;
 - (iii) communicate with the patient and other health care providers;
 - (iv) integrate information to evaluate the current health status of the patient;
 - (v) develop treatment goals and integrated plans of care in collaboration with the patient and other health care providers; and
 - (vi) provide continuity across care settings.
- f) support integration across health care providers and settings and provide the foundation for service integration, communication, and inter-professional collaboration;
 - g) support evidence-informed decision-making using an interprofessional practice approach to care delivery that is sensitive to scopes-of-practice, regulation and professional practice standards, professional judgement, and individual circumstances;
 - h) support safe practices and processes by utilizing a **Just Culture** where principles of appropriate accountability allow mistakes to be viewed as opportunities for learning and improvement;
 - i) support AHS in protecting and securely managing information in its custody and control;
 - j) be useful, accurate, efficient, and meet regulatory requirements while documenting decision-making, communication, and care; and
 - k) meet regulatory, legal, and AHS requirements regarding monitoring of health status, care effects, and outcomes of services provided to patients.

DEFINITIONS

Clinical documentation means the process by which health information is captured in electronic or written format on the clinical record to reflect patient care and to facilitate communication between providers. Clinical documentation also fulfills regulatory, legal and Alberta Health Services requirements regarding status, care, and services provided to patients.

Clinical record means the collection of all health records documenting health services provided and tracking the interactions with and communications between health care providers and the individual receiving health services.

Health care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

Health record means the collection of all records documenting individually identifying health information, in relation to a single person/patient.

Health service means a service that is provided to an individual for any of the following purposes: protecting, promoting or maintaining physical and mental health, preventing illness, diagnosing and treating illness, rehabilitation and caring for the health needs of the ill, disabled, injured or dying, but does not include a service excluded by the HIA regulations.

Just Culture means an environment where everyone feels safe, encouraged, and enabled to discuss quality and safety concerns.

Patient means an adult or child who receives or has requested health care or services from Alberta Health Services and its health care providers or individuals authorized to act on behalf of Alberta Health Services. This term is inclusive of residents, clients, and outpatients.

REFERENCES

- Alberta Health Services Policy Resources:
 - *Clinical Documentation Process Directive (#1173-01)*
 - *Collection, Access, Use, and Disclosure of Information Policy (#1112)*
 - *Contractor Requirements for Security and Privacy of Information and Information Technology Resources Policy (#1107)*
 - *Information Classification Policy (#1142)*
- Alberta Health Services Resources:
 - *Clinical Documentation Framework*
 - *Patient First Strategy*
- Non-Alberta Health Services Resources:
 - *Health Information Act [Alberta]*
 - *Health Professions Act [Alberta]*
 - *Health Disciplines Act [Alberta]*

VERSION HISTORY

Date	Action Taken
Click here to enter a date	Optional: Choose an item
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