Strategies for Improving Documentation

Lessons from Medical-Legal Claims

HIROC

A Guide for Healthcare Providers and Administrators

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I. Introduction

Why Document?

Proper documentation reflects the quality of care that you give to your clients and is evidence that you acted as required or ordered. (Yu, 2015, p.3).

Credible and defensible documentation is:

- ✓ Accurate and complete;
- ✓ Factual and objective;
- ✓ Chronological;
- ✓ Permanent and legible; and
- ✓ Contemporaneous (occurring in the same period of time).

Documentation is a key form of communication between healthcare providers. Not only does it provide evidence to support the quality of the care and decision-making, but it facilitates the continuity of care and reflects the patient's needs and perspectives. If the quality or safety of patient care is ever under scrutiny in a legal or disciplinary proceeding or investigation of a complaint, the health record becomes a primary piece of evidence in determining whether appropriate care was provided given the clinical circumstance.

Purpose of the Guide

This guide represents an update from the original April 2012 guide and includes recommendations for migration to electronic health records. Other sections of the guide have been updated based on emerging literature and best practices.

This guide has been written from the risk management perspective with the aim of enhancing team communication and continuity of care through improved documentation practices. We've included common findings from HIROC claims data, as well as insights from peer review experts. The guide complements clinical documentation standards and policies drafted by professional regulatory bodies and healthcare organizations.

Documentation's Impact on Medical-Legal Claims

Good notes contribute greatly to the successful defence of a legal action or response to a complaint to a regulatory body. Excellent notes can facilitate a prompt and successful resolution or, better yet, a dismissal of the action.
(Grant & Warner, 2009, webinar).

The health record is one of the key sources of evidence experts can rely on when they are preparing their views on a case, so it is critically important that documentation accurately tell the story of what happened.

The health record is used by healthcare providers and organizations (defendants), the patient (plaintiff), and the courts to assist in accurately recreating the episode of care and the events leading up to the incident in question.

Health records assist in:

- Reconstructing events
- Establishing times and dates
- Refreshing memories
- Resolving conflicts in testimony

Plaintiff's counsel analyzes the record to extract evidence to try to demonstrate where the healthcare organization and/or healthcare providers breached the standard of care. This is done by suggesting that lapses, errors, amendments, deletions, inconsistencies, and vague entries are evidence of the breaches in the standard of care. Defendants' counsel uses the same documentation to help establish their case.

In a case where there is inadequate or missing documentation, the courts will rely on the healthcare provider to testify as to their normal practice. Although this is an acceptable form of evidence, sole reliance on normal practice can significantly weaken the healthcare provider's case and put their credibility as a witness into question.

II. The Purposes of Documentation

When it's done well, documentation provides a clear indication of the healthcare provider's thought processes. The health record facilitates ongoing quality patient care by providing:

1. *An ongoing means of communication among healthcare providers* – the record is a complete, chronological and factual account of the care that has been rendered. Healthcare providers should be able to read and understand what was written, the condition of the patient, what treatment the patient received, at what time, on what date and who delivered the care.

2. *A basis for planning a course of treatment* – a healthcare provider's decisions about a patient's course of treatment is partly based on the documentation in the health record. Scant or missing information can lead to errors in treatment and possibly adverse outcomes.

3. *Support for quality improvement and health research activities* – the health record provides valuable health information for clinical audits and evaluation, peer reviews, and the assessment of patient outcomes.

III. The 6 Essential Elements of Good Documentation

Documentation should accurately reflect the needs of the patient, the treatments and interventions provided, and the patient's outcomes. Anyone reading the record should clearly be able to determine:

1. What care/service was provided
2. Who received the care
3. Who provided the care or service
4. When the care or service was provided
5. Why the care or service was provided
6. The patient's response and outcomes to the care or service provided

A good test to evaluate whether the documentation is well written is to answer the question: if another practitioner (e.g. nurse) had to step in and take over the care of this patient, does the record provide sufficient information for the seamless delivery of safe and competent care?

1 What care or service was provided

Healthcare providers should be clear and concise in their description of the care provided. Each patient contact, including the mode of contact if it is not in-person (e.g. by telephone, email, videoconference telemedicine), should be documented according to organizational policy and professional practice standards.

- Avoid ambiguity, judgmental adjectives, and verbosity – words such as "unintentionally," "inadvertently," and "unexpectedly" should be avoided as they reflect a judgment that something untoward happened.
- Try not to use subjective descriptions like "ate well" or "feels better". Where applicable, use the patient's own words, e.g. "Patient states she is feeling better."
- Do not leave blank lines between entries or blank spaces on paper records since this leaves the entry open to being altered.

Documenting Vital Signs – From HIROC claims files, we learn that the timely and consistent recording of vital signs becomes essential in cases where a patient's condition deteriorates and a claim of negligence is brought forward. In the absence of complete and timely

Case Study – Restraints

While residing at a long-term care facility, a resident was found with vital signs absent. When discovered, the resident was partially off the bed with a restraint vest on. The restraint vest was noted to be pulled up around the resident's back, with the left restraint vest tie pulled tight across the bed and sitting on the resident's neck.

Expert opinion was critical of the care provided to the patient, noting that under regulations outlined within applicable legislation, the use of vests or jackets as a mode of restraint was prohibited. Furthermore, a review of the patient's health record revealed that during the period that the patient was restrained, the involved healthcare team had failed to document assessment and monitoring of the patient. It was noted in the health record that the patient had a history of wandering, but the healthcare team had failed to document any discussion, attempted implementation or use of alternative behavioural management strategies.

Discussion Questions:

1. Reflecting on your own practice as well as your organization's policy/processes, discuss whether all patient checks/rounds need to be recorded in the clients' health record.
2. Can care providers safely rely on their normal practice as evidence that the patient check/rounds took place in the absence of related documentation?
3. While not evident in this case, would it have been appropriate to create late entries for assessments and monitoring that took place but was not documented?

Expectations for Students or Providers under Instruction, Supervision or Direction

There may not be enough space on a paper record to document that an assessment or procedure was done by a student or provider under instruction, supervision, or direction. The health record and the organization's documentation policy should reference that where two sets of signatures are present this indicates the assessment or procedure took place under instruction, supervision, or direction. The printed name and signature of the student and the healthcare provider providing the supervision should appear in the master signature list.

documentation, it is challenging to prove the assessments were performed and escalated to the most responsible practitioner where indicated. Vital signs and other patient assessments should be documented regardless of whether they were considered normal. Documentation of vital signs can assist in showing the patient was being monitored regularly and according to the plan of care. The documentation should clearly show what specific steps were taken in response to vital signs deviating from the acceptable range for that patient.

Anecdotal Notes – In situations that have not gone well, healthcare providers may feel it's necessary to make personal anecdotal notes. Given their probable subjectivity and potentially damaging consequences, personal notes are discouraged.

Contrary to common belief, personal notes are not private or legally protected and both working notes (e.g. vital signs recorded on a scrap piece of paper) and personal notes are producible evidence in a legal claim. Working notes should be transcribed onto the health record in a timely manner and then shredded.

If care decisions and rationale are not recorded, it is challenging if not impossible, to remember the facts of the events that occurred in sufficient detail.

2 Who received the care

Healthcare providers should ensure every page of the health record has the requisite patient identifier(s) to mitigate missing documentation when pages are separated from the health record. Patient identification on both sides of a double-sided form reduces the likelihood of the document being mixed up when it is photocopied, scanned, or faxed. In an electronic health record (EHR), ensure entries being made relate to the right patient.

3 Who provided the care or service

Anyone reading the documentation should be able to clearly identify the healthcare provider who performed the assessment, procedure or activity. Healthcare providers should put a dated signature or initial and professional designation on every entry. The full names and titles of all healthcare providers should be documented on a master signature list. There may be the rare instance when it becomes necessary to record the care provided by others (e.g. during a code blue), but in general such practices are discouraged.

Timing tips:

- To reduce timing discrepancies, healthcare teams should use one consistent source for timekeeping (e.g. synchronized hospital wall clocks).
- Regardless of the clinical setting, documentation should never be done in advance of providing care.
- Audit functionalities of an electronic health record automatically capture dates, times and user identifications (IDs) as entries made in the system. The fact that entries can be deleted or modified makes accurate documentation under these circumstances even more crucial. Audit trails help demonstrate the integrity of the documentation stored in the electronic health record and these trails are often presented as additional evidence to assist in the defense of claims.

Verbal Orders (including telephone orders)

There is an inherent risk in accepting a verbal order, and nurses should advocate for systems that allow their use only in emergency situations or when the order is unable to be documented. (College of Nurses of Ontario, 2015, p.5)

To help minimize the risks inherent with verbal orders, healthcare teams should adopt a structured communication approach so the order is read back and/or spelled out and a second person listens to the verbal orders where possible.

When receiving a verbal order, include:

- the name and signature of the transcriber, and the name of the healthcare provider who gave the telephone order;
- the verbal order details, including when the verbal order was initiated, and by whom

Verbal orders should be signed by the originator of the order upon his/her return to the healthcare organization. We recommend that healthcare organizations have defined policies around who can accept a verbal order (e.g. ward clerk) and under what circumstance. And we also suggest that you consider prohibiting verbal orders for higher risk medications (e.g. chemotherapy).

4 When the care or service was provided

The date and time of treatments, discussions or other provisions of care, as well as the date and time the healthcare provider records this information should be clearly documented. Timely documentation is especially important in high volume, acuity and turnover areas (e.g. obstetrics, the emergency department and intensive care unit) in order to keep members of the interdisciplinary team informed about changes in a patient's status.

Case Study – Resident Deterioration

While residing at a personal care facility, a resident was discovered with a reduced level of consciousness. A subsequent assessment revealed that the resident was unresponsive to stimulation on the left side of her body and was unable to swallow or follow verbal commands. When the resident was next assessed three hours later, she continued to exhibit concerning symptomology, including a weak gag reflex and ongoing apparent left-sided hemiparesis. Following this assessment, the resident's family was informed of the resident's health status. A decision was made to transfer the resident to tertiary care via emergency transport. Upon her admission to the emergency department at the tertiary care facility, it was determined that the resident had suffered a stroke.

Expert review of the case was critical of the care provided to the resident, noting a delay of over six hours between when the resident was first discovered with symptoms and when she was ultimately transferred to emergency care. They said the healthcare providers were slow to respond to the resident's apparent deterioration and had failed to initiate an appropriate stroke protocol.

A review of the patient's health record revealed that while the initial assessment was documented, no further monitoring was documented until the next formal assessment three hours later. Experts noted that the involved healthcare team had failed to record evidence of any escalatory measures that were taken prior to the patient's eventual transfer to tertiary care (e.g. consultation with the on-staff physician).

Discussion Questions:

1. In this case, experts concluded that "no further evidence of monitoring was documented prior to the next recorded formal assessment three hours later". Discuss if all assessment and vital signs need to be documented.
2. What should be documented following the initiation of a stroke protocol or medical directive?

Summary – the key purposes of documentation

1. An ongoing means of communication among healthcare providers.
2. A basis for planning a course of treatment.
3. To support continuity of care and reflect the patient's needs and perspectives.
4. Support for quality improvement and health research.
5. Evidence to support the practitioner's therapeutic relationship with the patient and commitment to high quality and safe care.
6. Evidence if the patient care is questioned during legal or regulatory body investigations.

Reconstructing a timeline

Memories fade with time – the longer the delay between the event and the recording, the more likely the possibility of incomplete information and errors. Delays in recording can also result in plaintiff's counsel claiming the care was inappropriate. Most medical-legal claims, with the exception of obstetrical and paediatric claims, remain open for an average of four to seven years. Obstetrical cases can remain open for considerably longer (18+ years). As the healthcare provider, you may be asked to recall – in minute detail – what took place years ago at a very specific date and time.

5 Why the care or service was provided

The purpose of each encounter should be included in the healthcare provider's documentation. Documentation should explain why the healthcare provider did what they did given the clinical circumstances.

6 The patient's response and outcomes to the care or service provided

To ensure documentation effectively tells the patient's story, you should always document the patient's response and outcomes to the interventions or care provided. Documenting the patient's response and outcomes demonstrates that the care provided was monitored from an effectiveness and safety perspective.

Case Study – Witnessed Fall

Following a post-operative follow-up appointment at an outpatient clinic, a 61-year old client slipped and fell on ice in the hospital's parking lot. The client's fall was witnessed by an employee of the hospital, who promptly attended to the client and helped him get up from the ground. The employee then persuaded the client to return to the clinic for further assessment.

After a cursory assessment by the clinic's attending physician, the client refused further treatment and left. After the fall, the client continued to experience severe pain in his right hip, groin and knee. Four months later, a bone scan revealed an undiagnosed right subcapital fracture with femoral head necrosis, which ultimately required surgical intervention.

Expert review of the case later revealed that while the involved employee and physician provided testimony that was indicative of an appropriate level of care, they were unable to corroborate and further substantiate their personal recollections, as they had failed to document the patient's fall, the subsequent assessment, and the client's informed choice to refuse further treatment.

Discussion Questions:

1. What are your organization's documentation practices/processes for witnessed and unwitnessed falls?
2. Should an incident report have been completed in the case described above?
3. What type of documentation should appear for an informed refusal of care or treatment?

IV. Special Considerations for Good Documentation

Incident Reports

The facts of a patient incident should be documented in the health record and in the incident reporting/management system. Documentation should just state the facts, not the health provider's subjective view of them – date and time of the incident, incident details, care provided, known outcomes, and who was notified.

The Incident Report is an organizational administrative tool and is not directly relevant to the care provided to a patient. For this reason, HIROC advises against the practice of recording in the health record that the Incident Report was completed or filing a copy of the report in the health record.

Informed Consent and Informed Choice

Allegations of failure to fully inform patients of the risks, benefits, alternatives, and anticipated outcomes are a common finding in HIROC claims. This is particularly true in cases involving fetal and paediatric patients and patient incidents following surgery or labour/delivery.

In many cases, the care provided was considered by peer review experts as being appropriate, however, the absence of good documentation surrounding the informed consent or informed choice discussion made it difficult to prove the patient or substitute decision-maker was fully informed of the risks and options.

In most jurisdictions the healthcare provider proposing the procedure or treatment is also the practitioner responsible for having the informed consent and choice discussion with the patient or legal substitute decision-maker.

As far as just how much information should be disclosed to the patient, the practitioner should consider what the average, prudent patient would consider 'reasonable' to make a decision given similar circumstances. The information should include material risks that are relevant for a broad range of patients, as well as information that is relevant for that particular patient.

In general, the greater the potential risk associated with the proposed treatment, the more detailed the documentation should be. The same is true of informed declines. Complete and timely documentation of an informed consent discussion is of particular importance if:

- the healthcare provider chooses not to follow the healthcare organization's policy based on the clinical issue;
- the patient's decision conflicts with recognized evidence-based guidelines, regulatory body standards, and/or hospital policies/procedures;
- it negatively impacts the healthcare providers' ability to provide adequate and safe care;
- it is associated with an elevated risk to fetal, neonatal, and/or paediatric patients.

Case Study – Informed Choice

A woman came into midwifery care at 32 weeks. Since she had a prior C-section, the midwife obtained the necessary information from the obstetrician involved. The woman elected for a trial of labour. The midwife's practice group protocol required such women to sign a 'VBAC consent form', which took place, in addition to the informed choice discussions. Spontaneous onset of labour was reported at term. The woman was monitored for five hours at home then transferred to hospital. Three hours post-admission, an obstetrical consult for oxytocin was obtained for labour dystocia. Full dilation was achieved four hours later. Due to severe bradycardia and difficulty obtaining a fetal heart rate during pushing efforts, the midwife immediately notified and involved nurses, the on-call obstetrician and paediatrician. The fetal heart rate remained difficult to obtain, and once obtained, a forceps delivery was performed. The infant was severely acidotic and was transferred to a tertiary facility. Long-term neurological sequelae could not be ruled out. With her detailed documentation of the informed choice discussion, the midwife's overall management during pregnancy and labour was considered by expert reviewers to be reasonable and defensible.

Discussion Questions

1. What is your current practice for documenting informed choice discussions?
2. If your practice group or hospital requires the use of a consent form for certain types of births and choices, can a primary care provider safely rely on the consent form as evidence that the woman was informed? Why?

Other Factors Pertaining to Informed Consent and Informed Choice

Translation services: The use of formal medical translation or interpreter services should be considered for higher risk or significant informed consent and choice discussions, mainly to ensure the information being relayed is accurate and understood. The healthcare provider should record the use of an interpreter, including his/her full name and relationship to the patient.

Consent and choice forms: While the use of consent and choice forms is not in itself the consent, the use of such forms is required in certain jurisdictions and may be helpful to demonstrate the patient's willingness to undergo the treatment if a question about it is raised in the future.

Regardless of whether the form is used or not, the proposing practitioner should record the informed consent and choice discussions, including risk, benefits, alternatives (including risk and benefits associated with the alternative) as well as key questions posed by the patient. When the discussions include handouts about clinic protocols to help inform the patient, the name of the documents should also be recorded.

The routine practice of asking nurses or other healthcare providers to obtain signatures for and witness consent forms is discouraged. Nurses are ethically and professionally accountable for ensuring the client is fully informed and capable of giving consent. He or she is responsible for:

- Clarifying that the patient understands what they are consenting to;
- Determining whether the patient's questions were answered by the proposing practitioner;
- Acting as the patient's advocate if further discussion with proposing practitioner is required.

Medical Directives

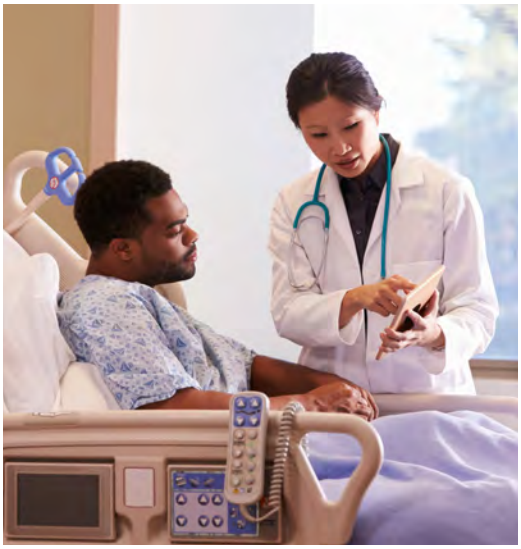
HIROC claims suggest that not all team members are aware of how medical directives should be used and who they apply to. Medical directives are written orders from healthcare providers for the performance of treatments, interventions or procedures on particular patients when specific conditions and circumstances are met.

While they can optimize patient care and efficiencies, a medical directive must also be vetted and approved by the appropriate team members.

If you are the healthcare provider implementing the order, you should document the following each time a medical directive is performed:

- Performance of the relevant assessments and findings (i.e., evidence the patient meets the specific criteria);
- The informed consent discussion;
- Date, time and the name of the healthcare provider initiating the directive;
- Name of the medical directive.

If you believe the directive should not or will not be implemented, the most responsible practitioner should be notified and this discussion and outcome documented.



Making Corrections and Deletions Properly

Corrections to errors in the health record can be done but must be done the correct way in a timely manner. Do not use whiteout, scribble over, black out or obliterate the original in any way – this can cast doubt on the truthfulness of the entire record as well as the credibility of the healthcare provider.

Healthcare providers should never delete, alter or modify anyone else's documentation.

In the written health record, errors should be corrected by placing one line through the incorrect entry and initialling the line. Document the correct information in the next available space and initial the date and time of the correction. With many organizations scanning paper-based health records and destroying the originals, writing in the margins may not be captured in the scanning process and is therefore discouraged.

Electronic health record systems may allow for corrections or deletions to be made by authorized individuals, but deleted entries within an electronic health record will not disappear completely. Based on the configuration of the system, corrections and deletions will be automatically tracked by the auditing functionality and saved into system logs. If auditing functionalities are available in the electronic health record, they should be turned on.

How to Manage Late Entries

Late entries should follow the same documentation practices outlined in this guide and be:

- Objective
- Factual/accurate
- Complete

Late entries, particularly those created days/weeks/months after an incident, are not surprisingly treated with suspicion by the courts who assume there is a cover-up of an error or mistake. In general, the later the entry is made, the greater the likelihood the credibility of the record will be called into question.

If you do have to document a late entry, acknowledge it as such. Be sure to include the date and time of the (late) entry, as well as the date and time (or approximation) of when the care, test, or intervention was provided.

Case Study – Alterations to the Chart

An infant sustained significant brain injury during the course of labour and delivery. One nurse, unable to recall the events of the labour and delivery five years previously, relied heavily on the health record. Hampered by incomplete and questionable records, the nurse was limited in her ability to disprove the allegations that there was a failure to provide adequate care. The court was critical of the alterations and additions made to the chart which called into question the accuracy of the entries recorded. Furthermore, the nurse had created an entry after the fact and this entry was not appropriately identified as such. This discovery cast suspicion on the reliability of the person who made the entries and undermined the accuracy of peer review opinions based upon these entries and observations. The nurse (and hospital) were found liable for the baby's injuries.

Discussion Questions:

1. With respect to alterations and corrections, discuss what your professional regulatory body standards and employing/credentialing organization's policies expect.
2. Is there is a different late entry 'standard' for community/home care providers versus hospital-based care providers?
3. When is it acceptable to record a late entry?

Review Your Entry for Legibility

A misplaced decimal point or illegible drug dosage can have enormous implications for the patient and the caregiver. Illegible handwriting leads to minor annoyances like communications breakdowns or time spent trying to clarify what the writer meant. One of the most serious consequences is patient harm through misinterpretation of prescriptions. Always review your entry for clarity and legibility.

In the event of a lawsuit, emails and text messages are producible in court.

In the written health record, black ink should be used because it photocopies well. Red ink or a symbol (e.g. an asterisk) may be used to highlight critical patient information such as allergies and key vital signs.

Email and Text Communications

Use of email and text can enhance communication but you should also be aware of the risks – security, confidentiality, and managing expectations related to response time.

Before you start communicating with a care provider or a patient by text or email, an informed consent should be obtained and documented in the health record.

Like all forms of communication, electronic communication regarding patient care must be documented in the health record, including all exchanges of emails and text messages. Always include the date and time of the email or text message, significant information, and outcome.

Charting by Exception (CBE)

The difficulty with charting by exception on a flow chart or graph is that when there are holes and blanks in the information, it leaves another observer wondering whether the observations were made, but not charted, or not made at all... (Skeels (Estate of) v. Iwashkiw, 2006).

In some organizations, charting by exception (CBE) is an accepted method of documentation. It's what occurs when routine care (e.g. hourly checks or observations) and care findings considered 'normal' or 'within normal/defined limits' are recorded in an abbreviated method (i.e., using flow sheets) with any significant findings or exceptions to norms documented in a narrative format.

When using CBE, it is important to establish baseline patient measures. Without them, it is impossible to determine what is considered normal or abnormal.

HIROC's claims experience indicates that CBE is frequently misunderstood by care providers, resulting in gaps in clinical documentation. For example, when asked to justify the missing documentation, some providers indicated that documentation was not required as 'everything was fine' or that the assessment/intervention was perceived to be 'routine' (e.g. vital signs) or 'within normal limits' (e.g. fetal heart rate pattern interpretation considered 'normal').

Case Study – Pressure Ulcer

After undergoing a surgical procedure, a 76-year old patient with paraplegia and G-tube feeding was admitted to a rehabilitation facility. Due to the surgery and other co-morbidities, the patient was unable to turn or re-position herself in bed. Prior to her transfer to the rehabilitation facility, she was identified as being at moderate risk for pressure ulcers.

One of the admitting diagnoses at the rehabilitation facility was a stage two decubitus pressure ulcer and heel ulcers. A specialized mattress was ordered five days after admission, but by this time, the ulcer had progressed to stage four with possible septicemia. Eight days after admission, the patient was transferred to an acute care facility after developing septicemia.

During the course of the internal review of the rehabilitation facility, one of the key gaps related to the failure of the care team to order a specialized mattress in advance of the patient's admission. While the records indicate that the nurses were aware of the ulcer's presence at admission, there was little to no documentation to suggest that they looked after the ulcer for the first five days following the patient's admission. Furthermore, there were no documented turning protocols in place throughout the patient's eight-day stay at the facility.

When speaking with the healthcare providers involved in the patient's care, it was determined that the long-term care facility's charting by exception practice was poorly understood. Routine care, including skin integrity assessment, ulcer staging, wound care, turning, etc. was not documented by the nurses as they were not considered to be "exceptional" findings. In addition, a review of the patient's health record indicated that a pressure ulcer risk assessment was never conducted upon admission.

Discussion Questions:

1. How can healthcare providers use documentation to support patients who have specialized equipment needs?
2. What are your organization's policies/practice expectations with respect to documentation related to wound care management, including patient turning/re-positioning protocols?
3. Does charting by exception mean that care/assessments often considered 'routine' are not documented?

CBE should only be used if:

- it is supported by organizational standards and policies;
- if there is a commitment to ongoing staff education and training; and
- there is ongoing evaluation of CBE documentation practices.

Checklists and Pre-Printed Templates

In many healthcare organizations and practices, traditional progress notes are replaced or supplemented by checklists and template forms with editable fields. When working with these forms, initial each checkbox or field to show that it has been reviewed and the date the care was provided aligns with the signature. Avoid leaving fields or checkboxes unanswered or blank; if a field is not applicable indicate such. Make sure you include the rationale on the checklist for the related tests or interventions ordered but not performed.

Records Retention

If one is not already in place, HIROC recommends that organizations develop a comprehensive records retention policy, addressing both statutory requirements and risk management considerations for various types of documents and electronic health records. Health records for paediatric patients (minors) are preserved for a longer period than for adult patients.

Retention guidelines are needed for such documents as Health Record-Related Documents and Administrative Records.

Health Record-Related Documents	
Fetal heart monitoring strips/ tracings	Flow sheets, checklists and forms used to record health data
Cardiac monitoring strips/ tracings	Patient monitoring logs (e.g. hourly checks for patients at risk of suicide, elopement or wandering)
X-rays, other imaging and requisitions	Healthcare provider signatures list
Laboratory test requisitions, results and patient notification	Kardex/face page
Instrument and sponge counts	Photographs and/or videos
Progress notes	

Administrative Records	
Shift assignment sheets	Internal claim files
On-call lists	Old, revised and obsolete contracts/ agreements
Paging records	Old, revised and obsolete policies and procedures (clinical and non-clinical)
Communication log books	Equipment work orders
Patient census sheets	Code cart checklists (if applicable)
Patient education materials	Narcotic records
Patient Relations files	Medication administration records
Incident/event reports	

Chart Audit Guide: a Valuable Quality Improvement Tool

Chart audits enable organizations to measure some component of team or practitioner performance through an analysis of health records. Focusing on the 'how' questions, a well-thought-out audit with an identified topic and defined measures is a valuable quality improvement tool.

Adherence to clinical policies and procedures and documentation practices are examples of what can be monitored and measured during an audit.

While the principles and recommendations included in this guide apply to most clinical practice settings, special considerations have been identified for select programs and settings (Mental Health, Emergency Department, Maternal-Newborn). Based on HIROC claims findings, we recommend that you consider using the checklists in the Chart Audit Guide, an appendix to this document. The checklists are a good starting point for auditing health records from a quality improvement perspective. HIROC's Risk Reference Sheets and Risk Notes also provide a comprehensive review of documentation-related risks and strategies.

V. Electronic Health Records (EHRs)

While EHRs have in many cases streamlined the sharing of health information, they also come with risks in the form of design flaws or system glitches with both human and technical elements. This portion of the guide explores those risks and other issues associated with EHRs.

What to do with paper records

Healthcare organizations often ask if paper records can be destroyed once they are scanned into the EHR. Migrated and scanned records are considered copies of the original records. Before proceeding with destruction of paper records, always check the quality and the completeness of the scanned health records. If a patient's complete health record is not converted, the system should be configured to alert the reader that a paper record exists.

Migrating to EHRs

a) Staff involvement

One of the biggest issues identified by The Joint Commission in the US is poor human-computer interface. For that reason, representatives from all disciplines (clinical, clerical and technical) should be involved in the selection, design, configuration, and testing of EHRs or other electronic systems. If possible, staff representatives should work with EHR vendors to incorporate solutions that would flag important clinical information such as abnormal test results or diagnostic imaging reports.

b) Migrating from Paper to EHRs

As healthcare organizations migrate to EHR systems, decisions have to be made with respect to conversion and retention of records. Again, healthcare providers, including those from health records and privacy, should be engaged to identify key health record elements (what data, which tests results, how far back to include and other important patient history) should be included in the conversion. If a patient's complete health record is not converted, the system should be configured to alert the reader of the existence of additional paper records.

c) Interconnectivity of Applications

With so many pieces of information and systems running simultaneously with EHRs, it is not unusual to experience a breakdown of communication between various clinical services and healthcare providers. A failure of interconnectivity of applications may contribute to significant patient harm. These events occur as a result of errors in data transmission rules, mismatched data fields/displays, or technology failures.

Before going live, we recommend extensive testing of the systems integration and having systems downtime drills on hardware and software and system-to-system interfaces to ensure data is not lost or incorrectly entered. All testing should involve frontline staff and users. These tests are vital to identifying vulnerabilities in the system and eliminating data integrity issues.

Security Protocols – Integrity of the EHR

EHR Access Management and User Identification (ID)

Healthcare organizations need to carefully manage access rights to the EHR. HIROC recommends implementing the following security precautions:

1. Only authorized individuals should have access to patient information in the EHR. These individuals are responsible for keeping their unique user ID and password secure and confidential. Sharing of user IDs among any healthcare provider, employee, student, volunteer or system administrator should not be permitted. All users should be provided with appropriate training and education on the organization's security protocols related to user access.
2. As healthcare providers change roles and responsibilities within an organization, their access rights should be reviewed and updated accordingly. All access control changes to the EHR should be assessed and approved by the area/department leader and a qualified systems administrator. Audits should be done on EHR access protocols to ensure compliance.

3. Appropriate timeout/lockout features should be applied to the EHR system so that patient information is not left unsecured.
4. Most electronic health information systems come with the ability to configure password structures. Use of a nine character length password, at minimum, with a combination of letters, numbers, and symbols is generally acceptable at this point in time. Where possible, organizations should deploy a password expiration policy (e.g. 90 days) and discourage password recycling practices.
5. All system logs such as user access logs, activity audits and metadata are tied to user IDs. The EHR system should not allow any changes to these logs. If the logs are compromised, the integrity of the documentation in EHRs may be questioned if the records are reviewed during legal proceedings.

EHR-facilitated documentation is not a substitute for the healthcare provider's narrative reports.

Documenting in the EHR

The importance of narrative notes

Misconceptions abound that EHRs will improve efficiency and reduce time associated with documentation due to system-facilitated features such as dropdown fields and multi-pick boxes. EHR-facilitated documentation is not a substitute for the healthcare provider's narrative reports. This narrative documentation is essential for capturing the logic behind the healthcare provider's decision- making process.

The same principle holds true for system-facilitated features such as dropdown fields and multi-pick boxes. These drop-down field selections and checkboxes are not a substitution for narrative notes. Narrative notes should be required for important clinical events, including transfer of care, changes in patient condition, consent discussions and incidents. All communication with the patient or substitute decision-maker, family members, and other care providers should also be documented factually and concisely.

Furthermore, the identification of the healthcare provider must be captured automatically by the EHR for each entry and action (e.g. entry, modification, deletion). All healthcare providers assigned to a patient should have complete read and/or write access to the patient's information.

The documentation and progress notes of all healthcare providers should be well integrated and seamless – a necessary step in avoiding communication breakdowns.

Editing, Correcting and/or Deleting

Unlike paper records, edited, corrected, or deleted notes may not be readily visible in EHRs. If a correction of previously entered information is required, the EHR should be able to track who made the change, the reason for the change, and when the change was made. Ensure the original information remains visible or is easily retrievable by healthcare providers and other users. Audits should be performed to monitor editing, correcting, or deleting of electronic health information.

Copy and Paste

One of the most egregious dangers of electronic charting lies not in a deficiency but in a feature, the copy-and-paste function, which allows an author to copy information from a prior note and paste it into a new note.
(Siegler & Adelman, 2009, p. 495).

Potential risks associated with a copied and pasted note include:
- inaccurate or outdated information
- repeated information leading to excessive or lengthy documentation
- reproduction and continuation of potential errors in the documentation
- inability to identify the origin of the documentation.

Overuse of the copy and paste function can put both the credibility of the patient record and the healthcare provider into question during legal proceedings or college investigations.

Copying content from one patient's EHR to another patient's EHR should be prohibited. This can be accomplished by limiting the number of patient records, including windows that can be opened at the same time on a computer.

Some EHRs and electronic systems allow for tracking capability, which shows when information is moved from one place to another and by whom. Understanding the capabilities of EHRs and electronic systems and working with your organization's IT department will help you make the appropriate decision regarding this practice.

Some users may use the keyboard commands Ctrl-C and Ctrl-V to duplicate highlighted content from another part of the EHR or an electronic document. You can prevent this by disabling the 'content highlight' feature or the Ctrl-C and Ctrl-V keyboard commands.

Case Study – Copy and Paste

While recording in the EHR, the provider copied the previously entered progress note and pasted it into the current entry field in order to save time. Unfortunately, the previously entered note had an error with respect to the patient's status, which resulted in the mistake being replicated several times in the future.

Later, the patient went on to have a poor outcome leading to a legal proceeding. When the clinical experts reviewed the patient's health record in preparation for the legal proceeding, they found progress notes that had been copied and pasted. The credibility of the healthcare provider was called into question with a finding of substandard care being provided.

Discussion Questions:

1. What are some of the risks associated with EHRs' copy and paste functionality?
2. Reflecting on your regulatory body standards and healthcare organization's policies, are care providers accountable for the accuracy of their entries, including situations where incorrect or out-of-date information is copied and pasted from a prior client encounter?
3. If copy and paste is allowed at your healthcare organization, what safeguards at both the care provider and system level are in place to minimize the related risks?

Be sure to back-up EHR data!

Regular back-up of EHR data and system configurations is critical. The back-ups should be kept in a separate network to protect against network breaches or malware/virus/ransomware attacks and off-site to protect against physical losses (e.g. fire, water). In addition, as part of business continuity processes, restoration of systems and data from off-site back-ups should be tested regularly to identify potential issues.

Make Sure Your Audit Trail is Secured

Healthcare organizations should understand the EHRs' audit tracking and metadata capabilities and ensure they are all activated. Audit results are especially important when reviewing a possible privacy breach. The audit function should include:

- Who accessed the record, when, and for how long?
- What, if any, alterations were made?
- Which terminal was the record accessed from?
- When were tests ordered, results available/accessed, etc.?

In order to ensure that EHR audit trails are secured, accurate and reliable, audit trails should only be accessible by authorized individuals and should not be editable.

In some organizations, information technology or system administrators may have access rights to update individual or groups of records within the EHR or 'behind the scenes' audit trails and metadata. These activities should be discouraged. A comprehensive EHR system would have capabilities to automatically track these types of activities.

Destruction of Records

As with paper records, appropriate policies, procedures, and guidelines should be established and followed when destroying electronic records according to your healthcare organization's retention schedule. When retiring or disposing of electronic storage devices, healthcare organizations must ensure the records stored in these devices are securely destroyed.

Legal Considerations

In contrast to paper health records, EHRs allow for the storage of vast amounts of information related to patient care. An EHR system that is not well-designed can cause healthcare providers to overlook or miss key clinical findings, increasing the possibility of patient harm. EHRs increase healthcare providers' responsibility and accountability with respect to reviewing, comprehending and documenting personal health information.

Audit logs, including EHR access/log-in audit logs, are often used as evidence when allegations of privacy breaches arise. Failing to turn on audit functionalities of EHR systems, retain the audit logs and protect the audit logs from potential tampering poses risks to healthcare organizations.

Finally, healthcare organizations should develop clear policy and procedures, education and training to promote good documentation practices and appropriate use of EHRs.

Healthcare organizations should monitor who has access to the audit logs and monitor the activities of system administrators to protect the integrity of these logs.

Final Tips on Working With EHRs

- Minimize the use of templates, macros, and auto-populated fields in EHRs to automate or semi-automate documentation creation processes. This can lead to under-documentation of actual patient encounters or documentation errors.
- Scheduled downtime of EHRs or other systems should be meticulously planned, communicated and monitored to ensure access to health information is not negatively impacted; documentation of new health information is not delayed; and post downtime activities are carried out appropriately. HIROC recommends extensive testing, including downtime drills involving frontline staff, to identify potential issues before they occur.
- Printed records from EHRs rarely look the same as they appear on the screen, which can create problems when healthcare providers have to re-visit records in the future, particularly in the context of a medical-legal claim. Healthcare providers should familiarize themselves with the available printed views of their EHRs and know how to modify them if the need arises.

Conclusion

Documentation is an essential component of a healthcare provider's daily practice. With this guide we have given you practical advice and recommendations related to documentation based on learnings through the medical-legal process. If followed, these steps should reduce the likelihood of your having to defend documentation practices. The real benefit of strong documentation practices is improved team communication and continuity of care.

The quiz and electronic health records checklist will assist subscribers in building capacity in their organizations with respect to comprehensive documentation practices.

Case Study – System Downtime

During an unplanned system downtime, a patient was sent for an ultrasound. The ultrasound was ordered using the downtime paper process and was completed. The results confirmed appendicitis. The paper report with the results was waiting to be reviewed by the healthcare provider. When the system came back online, the paper report was scanned into the electronic health record. The report was not flagged for review in the electronic health record. Regrettably, the result was not communicated to the physician, leading to a delayed diagnosis.

Discussion Questions:

1. Does your organization have a business continuity or emergency response plan for system downtime?
2. Are healthcare providers aware of the system downtime processes?
3. Does your organization have written policies and procedures for post-downtime activities, e.g. scanning of paper reports, flagging reports that have not been reviewed, scanning or entering clinical notes, or flagging information that was entered late due to system downtime?

Electronic Health Records Checklist

The following checklist summarizes important considerations when implementing and utilizing EHRs.

- ✓ Involve healthcare providers, including representatives from all disciplines (e.g. clinical, clerical and technical) when selecting, designing, configuring and implementing EHRs or other electronic systems.
- ✓ Before going live and as appropriate after implementation, conduct extensive testing, including system downtime drills and system integration to identify system vulnerabilities.
- ✓ Limit record entries to authorized individuals with the identification of the recorder captured for each entry.
- ✓ Work with the IT or the EHR vendor to fully understand the impact of system generated warnings/alerts and clinical decision support systems on patient care documentation.
- ✓ Ensure that audit trails with the original copy of the documentation and time stamp are retained when it is edited or deleted.
- ✓ Do not rely on drop-down field selections and checkboxes alone to provide a complete record of patient care. Where possible, encourage and enable users to enter narrative notes. Narrative notes should be mandated for important clinical events, including admissions, discharge, procedures, transfer of care, and patient safety incidents.
- ✓ Work with the IT or EHR vendor to set up the use of different fonts, mixed case letters and logical groupings of lists. Avoid sorting in alphabetical order to eliminate selection errors from drop-down lists.
- ✓ Due to potential risks involved with the copy and paste functionality, healthcare organizations should consider disabling this function.
- ✓ Minimize the use of templates, macros or auto-populated fields in EHRs and other electronic systems to automate/semi-automate documentation creation processes.
- ✓ Healthcare organizations should understand the EHRs' audit tracking and metadata capabilities and ensure the IT department or vendor has activated them. In order to ensure that the EHRs are secured, accurate and reliable, audit trails should only be accessible to authorized individuals and should not be editable.
- ✓ Scheduled downtime of EHRs or other systems should be meticulously planned, communicated and monitored to ensure access to health information is not negatively impacted, documentation of new health information is not delayed, and post downtime activities are carried out appropriately.
- ✓ Healthcare organizations implementing EHRs should consider the printed format when selecting an EHR system solution or vendor. Healthcare organizations that have already implemented EHRs should familiarize themselves with the available printed views of the EHRs and understand if the print views can be modified if the need arises.
- ✓ Develop clear guidelines, education and training to promote good documentation practices and appropriate and meaningful use of EHRs amongst healthcare providers. Put controls in place to monitor compliance and identify initial signs of documentation and communication issues.
- ✓ Policy, procedures, and guidelines around destroying electronic records should be put in place and should address procedures related to secure disposal of electronic storage devices that stored personal health information or other sensitive records.

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Documentation Quiz

1. Less is more. The less documented the less to explain in legal and regulatory body proceedings. You can rely on your normal practice, your facility's policies/protocols and your workload measures/stats as evidence of care provided.

   Answer: False – a healthcare provider's 'normal practice' does play a role in such proceedings; however, it may not be sufficient. During legal and regulatory body proceedings, the quality and safety of the provider's care and decisions are carefully scrutinized. For example, plaintiff's counsel often looks for documentation gaps and deficiencies as evidence of poor quality and breach of the standard of care.

2. Poor documentation can lead to legal findings of negligence.

   Answer: True – as we learn from HIROC medical-legal claims, poor documentation can negatively impact the credibility of the provider and the health record as evidence. Peer expert opinion is based on the quality of the documentation in the health records.

3. Healthcare providers working in hospital settings are held to a higher documentation 'standard' than their community and homecare peers.

   Answer: False – while some documentation styles and practices may differ depending on the setting, healthcare providers will be held to the same documentation standards, regardless of setting, as defined by their professional regulatory body.

4. It is not a "late entry" if it is done within 24-48 hours.

   Answer: False – healthcare providers are encouraged to review their professional regulatory body standards surrounding late entries. What is considered 'late' may be interpreted differently by facility policy, professional regulatory body standards and in the court room. What may be considered a late entry by the courts may differ from what is considered a late entry by a regulatory body. In general, entries created 24-48 hours after care was provided are not considered contemporaneous (existing or occuring in the same period of time).

5. Medical records are important in determining the outcome of a legal action as they can document events that occurred years earlier.

   Answer: True – it is unrealistic to expect healthcare providers to recall – in minute detail – events that occurred a week ago let alone years later.

6. A healthcare provider records the following entry into the EHR: "Physician notified of client's deteriorating condition". Is this documentation adequate and sufficient?

   Answer: False – this example of documentation does not include the name of the physician, the method of contact, the reason for contact and if there were new orders or no new orders.

Appendix – Chart Audit Guide

Program Specific Recommendations for Audits

The following checklists focus on program-specific documentation recommendations based on HIROC claim findings and can be incorporated into chart audit practices. This is not meant to be an exhaustive list, but a starting point for conducting chart audits. When implementing the checklists, consider how often the element is recorded, the quality of the recording, and whether the recording was made contemporaneously.

All Sectors (Acute Care, Non-Acute Care, Long-Term Care, Mental Health)

Patient/Client/Resident Deterioration

☐ Complete and timely documentation of:

- Vital signs and other patient/client/resident observations regardless of whether they are considered normal
- Interventions (and their effectiveness) to treat deteriorating patients, including code responses if applicable.

Restraints

☐ Complete and timely documentation of:

- The behaviour that initiated the restraint use or its continued usage
- A detailed assessment of any underlying etiology that contributed to the behaviour
- Steps taken to correct the underlying etiology
- What interventions/alternatives and de-escalation strategies were attempted
- Patient and family/SDM involvement in the decision-making process, any discussions and outcomes
- Team members involved in decision to initiate restraint
- Type of restraint used
- Date and time of restraint application and healthcare providers involved
- Documentation of reassessment and monitoring, ongoing use of alternatives and de-escalation strategies
- Documentation that the family/SDM has been informed about the initiation of restraint (if applicable)
- Restraint assessments/screening, goals, re-assessments/reviews and removals (including date/time)
- Restraint orders/approvals from the most responsible provider/physician
- Behaviour of patient while in restraints
- Vital signs
- Skin integrity
- Toileting regime
- Detailed skin assessment
- When patient is restrained, document scheduled and PRN checks/rounds/assessments
- Discontinuation of restraint, by whom, date and time – include description of patient's response and/or outcome of restraint

Pressure Ulcers

☐ Education/training provided to patients and families surrounding pressure ulcer prevention strategies and encourage compliance with treatment regimes

☐ Standardized terminology for pressure ulcer staging is consistently used

- ☐ Complete and timely use of the validated pressure ulcer assessment tool
- ☐ Complete and timely use of the standardized record to track ulcer staging, treatment effectiveness and ongoing assessment
- ☐ Complete and timely documentation of all:
  - Assessments/re-assessments, including date and signature of the person performing the assessment
  - Interventions performed in response to changes to skin integrity or wound status
  - Scenarios where a patient or family/SDM who choose to not follow the prevention strategies encouraged by the healthcare team.

Patient/Client/Resident Falls

- ☐ Standardized falls risk assessment screening tool was completed in a contemporaneous manner, including analysis of medications
- ☐ Complete and timely documentation of falls prevention/injury reduction intervention plan
- ☐ Education/training provided to patients and families surrounding fall intervention and prevention practices
- ☐ Action taken in response to suspected, reported or witnessed fall.

Mental Health

Searches and Restraints

- ☐ Patient/patient belonging searches performed (consent/order/authorization, staff in attendance, findings, etc.)
- ☐ Refer to section above re: restraints.

Elopement Risk

- ☐ Elopement risk assessments performed (i.e. admission to the unit, triage and at predetermined intervals as defined by care plan)
- ☐ Interventions to address the patient's risk of elopement, goals to prevent harm to the patient and/or third parties (i.e. within patient's care plan)
- ☐ The steps undertaken in response to suspected elopements by voluntary or involuntary patients, including:
  - Who was contacted (security staff, most responsible physician, family, police, etc.) and when
  - When code yellow/missing person was initiated.

Suicide Risk

- ☐ Suicide risk assessments performed (CAMH, 2011), including:
  - Admission to unit or at triage
  - Change to status and/or to treatment plan
  - Prior to increasing/decreasing the patient's level of care/observation
  - Threats/incidents of suicidal ideations
  - Concerns related to suicide expressed by substitute decision maker/family
  - Prior to granting passes and leaves

☐ Suicide management, observations and communications, including:

- Interdisciplinary care plan (clear, timely and complete)
- Scheduled and ad hoc patient assessments (including level of assessed suicide risk, nature of the risk and steps taken to ensure the patient's safety) and safety checks/rounds
- Clinical rationale for increasing or decreasing level of care/observation
- Communications with family/substitute decision maker and family provider (where permitted)
- All call/paging attempts to most responsible physician/provider (including the name of the provider, time called and level of urgency/risk communicated).

Emergency Department

Adult and Paediatric Patients

☐ Full set of vital signs (heart rate, respiratory rate, blood pressure, temperature, plus or minus oximetry, Glasgow Coma Scale and pain scale) for assignment of triage level

☐ Review/assessment of all systems

☐ Assessment of pain (character, radiation, duration, onset, location, intensity, behavioural/physical signs of pains for children/neonates)

☐ Triage documentation adequate to assess appropriateness of triage level

☐ Required medical directives implemented (name of initiator, directive name/number, and date time initiated, follow-up on ordered tests)

☐ Risk factors (mechanism of injury, cardiac, co-morbidity, age, victim of violence, parental concerns)

☐ Scheduled patient re-assessments (as per CTAS guidelines) prior to physician/nurse provider assessment, including re-evaluation of chief complaint

☐ Patient refusals of examinations, violent patient (Code White), treatments and/or transfer

☐ Adequate discharge instructions (including the name of and/or a copy of printed discharge instructions)

☐ Action take in response to patients leaving without been seen/against medical advice/elopement.

Mental Health Patients

☐ Appropriate and clearly defined level of care/supervision for patients at-risk of harm to self or others, or elopement

☐ Scheduled and ad hoc risk assessments and checks/round (as per defined level of care/supervision).

Maternal-Newborn

Induction/Augmentation Medications

Midwives and nurses

☐ Consultations with physicians regarding orders for induction/augmentation, including:

- Name of the ordering/consulting physician
- Date/time the order/consult took place
- The fetal status and risk factors relayed at the time of discussion/consultation

- The findings and recommendations
- Changes to the birth plan/management plan

☐ Rationale for accepting an order, continuing and/or increasing the rate of infusion in the presence of maternal or fetal contraindications ('as per protocol' or 'as per orders' is not sufficient)

☐ Documenting the "chain of command" in the event of concern regarding the use of oxytocin

☐ Frequency of documentation is appropriate depending on stage of labour

☐ Intrauterine resuscitative measures in response to abnormal or atypical fetal assessments

☐ Accurate charting with respect to the decrease or discontinuance of oxytocin.

Fetal and Maternal Monitoring During Labour

☐ Informed consent/choice discussion surrounding method of fetal surveillance used (SOGC, 2007)

☐ Fetal and maternal assessments performed, regardless of whether the findings are considered normal, atypical or abnormal, including:

- Assessment of intermittent auscultation (IA) (i.e. uterine activity [frequency, duration, intensity and relaxation between contractions], FHR [baseline, rhythm and gradual/abrupt deceleration or acceleration] and provider interpretation)
- IA performed when the patient is discontinued from continuous electronic fetal monitoring (EFM) (e.g. ambulation, shower, labouring in water, preparation for and/or transport to the operating room)
- EFM assessments (i.e. uterine activity [frequency, duration, intensity and relaxation between contractions], FHR [baseline, variability, presence/absence of accelerations, presence and type of decelerations, changes in baseline trends over time] and provider interpretation)
- Fetal assessments performed by nurses when managing patients of midwives with epidurals and/or IV oxytocin inductions/augmentations (where this practice is in place)

☐ Use of standardized neonatal resuscitation and stabilization record/form, prompting the recording of key information, such as the sequence, time and effects of the interventions

☐ Emergency delivery preparations including sequence of events and effects (e.g. ongoing fetal assessments, intrauterine resuscitation, call for help, OR notified).

Vaginal Birth after Prior C-Section (VBAC)

Midwives and physicians

☐ Detailed VBAC care management plans including:

- Discussion of the informed choice/consent discussion, including risks to the maternal and fetal patients
- Signed consent form (where utilized in addition to informed choice discussions)
- The patient's overall/'big picture' and evolving clinical scenario
- The patient's risk factors, predictive factors and contraindications
- Plans for the possibility of post-dates pregnancy
- Method for monitoring fetal status during labour (where options are available)
- Local/privileging hospital's resources (e.g. scheduling an induction of labour, scheduling an elective C-section and performing an emergency C-section)

☐ Informed choice/consent discussions and documentation, including material risks and fetal patients benefits and alternatives associated with:

- Trial of labour after C-Section
- Trial of labour with pharmaceutically induced/augmented labour
- Repeat elective C-Section
- Intermittent auscultation (IA) versus continuous electronic EFM during labour (where choice requested/offered).

Midwives

☐ Informed choice discussion (detailed – risks to the maternal client and fetal/neonatal client) surrounding planned out of hospital VBAC births, including:

- Emergency measures available/not available (e.g. "I am aware that on site C-section or access to an obstetrician or anaesthesiologist is not available at my nearest hospital")
- Availability of continuous electronic fetal monitoring (EFM) for labour (e.g. "I am aware that continuous EFM is not available")
- Distance from home/birth centre to hospital with C-section capability:
    - Transport plan
    - The woman's awareness that their choice(s) conflicts (where conflict exists) with applicable midwifery, obstetrical (i.e. SOGC) or hospital/health region VBAC-related policies/protocols.

Assisted Vaginal Deliveries

Physicians

☐ Rationale (detailed and complete) for:

- Not performing assisted vaginal deliveries in C-section ready room if the vaginal birth has a higher risk of failure or is considered a trial
- Continuing the assisted vaginal delivery and/or not proceeding directly to C-section in the presence of lack of descent with moderate traction and/or where delivery is not imminent following three contractions with correctly applied instrument.

☐ Management of the assisted vaginal delivery, including:

- Manual rotation attempts (where applicable) prior to assisted vaginal delivery
- Position and station of fetal head
- Amount of moulding and caput present
- Assessment of maternal pelvis and fetal status
- Classification by station (e.g. outlet, low, mid and high)
- Informed consent, including risks and benefits to baby, but also including increased risk of trauma to the infant with sequential use of instruments and use of translators or interpreters (i.e. name and relationship to the maternal patient)
- Instruments used
- Indication for use and evidence that prerequisites were fulfilled
- Duration of traction
- Traction/force used
- Number of attempts
- Maternal and neonatal complications.

Shoulder Dystocia (SD)

Midwives and physicians

☐ Management of the SD, including:

- Exact time and how SD was encountered
- All personnel called/paged to attend (name, time called and time arriving)
- Maneuvers attempted and by whom
- Sequence and duration of each maneuver attempted
- Which fetal shoulder was anterior and which was posterior
- Application of suprapubic versus fundal pressure
- Position of the fetal head at delivery
- Exact delivery time for head and body
- Degree of traction applied
- Assessment of the infant (Apgar's, cord blood values, weight, description of injuries and bruises), including whether a paediatrician/neonatologist consult was requested
- Maternal injuries.

Midwife Initiated Consultations and Transfer of Care

Midwives and nurses

☐ Attempts (including date/time) to arrange a physician consultation or transfer of care, for example:

- The names of the consultant providers
- Date/time the consult or transfer of care request took place
- The reason for the consultation or transfer of care request and level of urgency
- Recent and concerning historical fetal or neonatal assessments relayed
- The consultant's response/recommendations
- Consultant's agreement to accept (or decline) consultation or transfer of care (when indicated)
- Physician's anticipated and actual response time/attendance time in response to pages/calls (during labour/delivery)
- Confirmation as to the roles of the referring provider and consulting physician.

Neonatal Hyperbilirubinemia

☐ Jaundice instructions/education provided to parents (including name of any handouts provided)

☐ Parental concerns regarding neonatal jaundice, lethargy, weight loss, breastfeeding, etc. and the provider's advice/recommendation (i.e. what was specifically offered and/or recommended)

☐ Where utilized, implementation of required newborn and hyperbilirubinemia-related medical directives (name of initiator, directive name/number, date time initiated, follow-up on ordered tests):

- Notification to the MRP of test results, where required, including level on age specific nomogram
- Notification to the MRP if the nurse/staff believes the directive should not or will not be initiated

☐ Jaundice assessments (including those performed remotely) and screening/testing performed regardless of whether the findings are normal, atypical or abnormal including:

- The rationale for not performing routine screening, follow-up testing ('declined' or 'early discharge' is not adequate documentation) and/or phototherapy or exchange therapy where clinically indicated

- Point of care testing (e.g. bilimeters)
- The identification/receipt of a positive direct antiglobulin test (DAT) or critical transcutaneous bilirubin (TcB)/ total serum bilirubin (TSB) value (i.e. date/time received; date/time MRP notified and his/her name; response/ action taken)
- Midwife and nurse providers' consultations with physicians.

Postpartum Hemorrhage (PPH)

Midwives and Physicians

☐ Informed choice/consent discussions (detailed) surrounding expectant versus active management of the third stage of labour

☐ Systematic management of the PPH, including:

- Who and when assistance was called (including physicians, nurses, maternal support workers and emergency medical services in the out of hospital birth locations) and their arrival time
- Timing of prophylactic and emergency pharmacological medications, their sequence and the maternal response
- Fluids administered and vital signs
- Amount (ideally measured versus estimated), colour, consistency and pattern of bleeding.

Nurses

- Recording of frequency of vital signs and blood loss
- Communication to physician regarding volume loss and concerning vital signs

Placental Evaluations

Midwives and physicians

☐ Request for pathological examination of placentas

☐ Gross placenta examination following all births, including:

- Time placenta exam was performed
- Placenta's completeness (including estimated amount missing), intactness, size, consistency, shape and maternal and fetal placental surfaces
- Umbilical cord's length, thickness, knots and number of vessels
- Studies ordered (e.g. placenta to pathology)
- Placenta's disposal.

HIROC

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