Key Assumptions

The information contained in this professional practice guideline is intended to supplement your employer’s policies and procedures with respect to the documentation of patient and client care. Please refer to your employer’s current policies and procedures and follow their direction.

This document is intended for information purposes only and is not intended to be considered as legal advice or to be used in place of legal advice. Please consult a qualified lawyer for any legal advice.
Table of Contents

Introduction ............................................................................................................................................................ 3
What is Health Information .................................................................................................................................. 4
Reasons (Purposes) for Documentation .............................................................................................................. 5
Tools for Documentation ..................................................................................................................................... 6
Safety Learning (Incident) Reports ..................................................................................................................... 6
Legal Guidelines for Recording .......................................................................................................................... 7
Legislation ............................................................................................................................................................ 8
Purposes of Health Information Act .................................................................................................................. 8
Standards of Practice Regarding Health Information ......................................................................................... 9
Documentation Methods ................................................................................................................................... 10
FOCUS Charting .................................................................................................................................................. 10
SOAP Charting .................................................................................................................................................... 10
Narrative Charting .............................................................................................................................................. 10
Charting by Exception ......................................................................................................................................... 11
What Does It Mean to Co-sign/Countersign? ..................................................................................................... 11
Application of Technology .................................................................................................................................. 12
Electronic Health Record .................................................................................................................................. 12
Guidelines for Using Electronic Health Records .............................................................................................. 13
Telehealth .......................................................................................................................................................... 13
Frequently Asked Questions ............................................................................................................................. 15
Appendix 1: Do Not Use Dangerous Abbreviations, Symbols, and Dose Designations ............................... 16
Appendix 2: Guidelines on Facsimile Transmission .......................................................................................... 17
Appendix 3: CARTA Standards of Practice ...................................................................................................... 19
Appendix 4: CARTA Code of Ethics .................................................................................................................. 26
Bibliography ......................................................................................................................................................... 27
Introduction

Per our Standards of Practice, each Registered Respiratory Therapist is expected to “appropriately document on paper and/or electronic form, all information regarding initial assessments, patient response to therapeutic interventions and follow-ups and discharge plans¹”. The documentation must be “legible, comprehensive, concise, and pertinent²”. Each entry shall include the date and time and the protected title and signature of the registered respiratory therapist and be performed in a timely manner.

Documentation is a vital element in the practice of respiratory therapy helping ensure safety and accountability and is an expectation across all practice settings. This expectation does not change even if documentation systems are paper or electronic. Respiratory therapists must follow all employer policies and guidelines where they exist. Where no employer policies exist this guideline and professional judgement should guide practice.

Documentation shall provide an accurate and honest account of what and when events occurred including the identity of the care giver. 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 (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 abbreviations³. 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.

¹ College and Association of Respiratory Therapists of Alberta Standards of Practice 2.4
http://www.carta.ca/AboutUs/StandardsofPractice.aspx
² ibid
³ https://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf (Appendix 1)
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.

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.

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

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. Health information also includes personal also called “registration information” as defined in the Alberta Health Information Act 4(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,”

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,

4 http://www.qp.alberta.ca/documents/Acts/H05.pdf
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 (Purposes) 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.

The record can be used for:

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

**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 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.

**Education** – By reading the patient care record you can learn the nature of an illness and the patient’s response to that illness.

**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.
Tools for Documentation

Worksheets/Kardex
Worksheets or Kardex are medical information systems used by respiratory therapists or other medical staff to communicate important information on their patients. It is a quick summary of individual patient needs that must be updated at every shift change. To be useful it must be accurate and is often used as an aid when giving report. These are transitory records and are not part of the permanent record and must be destroyed when no longer required.

Care Plans, Maps, Clinical Pathway and Protocols
Documents that identify orders for a patient and serves as a guide to patient care. It can be written for an individual patient, be retrieved from a computer and individualized, or be designed for a specific disease condition or diagnosis and individualized to a specific patient.  

The care plan is a means of communication and helps organize activities of constantly changing staff. It also assists with charting as to what observations must be carried out and actions need to occur.

A protocol also called a clinical guideline, clinical protocol or clinical practice guideline is a document with the aim of guiding decisions and criteria regarding diagnosis, management, and treatment in specific areas of healthcare.

Flowsheet
A flow sheet is simply a one- or two-page form that gathers all the important data regarding a patient's condition. The flow sheet is housed in the patient's chart and serves as a reminder of care and a record of whether care expectations have been met.

Monitoring Strip
Examples of monitoring strips include electrocardiograms and pulse oximetry results. Pulse oximetry can be used to qualify patient for oxygen therapy. The expectation is that the patient will be stabilized and that the pulse oximeter is correlating patients heart rate. Monitoring strip includes patient information, testing conditions, time date and name of individual performing the test.

Safety Learning (Incident) Reports
These systems provide respiratory therapists with the opportunity to report hazards, hazardous situations, errors, close calls and adverse events. The information from these reports make it possible for an organization and it’s people to learn and be accountable. When safety is the primary goal, reporting should be confidential, voluntary and easy to perform and should lead to risk mitigation strategies following appropriate analysis. If properly designed and supported, a reporting system can be an important component of an organizational strategy to foster a safety culture.
<table>
<thead>
<tr>
<th><strong>Legal Guidelines for Recording</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Do not erase, white out, or scratch out errors made while recording</strong></td>
</tr>
<tr>
<td>Correct Action: draw a single line, write error above it &amp; sign and date it, then record correctly</td>
</tr>
<tr>
<td><strong>Do not document retaliatory or critical comments about patient or care by others. no personal opinions</strong></td>
</tr>
<tr>
<td>Correct: Enter only objective and factual observations of patient's behavior. Quote all patient comments</td>
</tr>
<tr>
<td><strong>Correct all errors promptly</strong></td>
</tr>
<tr>
<td>Correct: Avoid rushing to complete charting; be sure that info is accurate and complete</td>
</tr>
<tr>
<td><strong>Record all facts</strong></td>
</tr>
<tr>
<td>Correct: Be certain every entry is factual &amp; thorough. Personnel should be able to determine the patient had adequate care.</td>
</tr>
<tr>
<td><strong>Do not leave blank spaces in notes</strong></td>
</tr>
<tr>
<td>Correct: Chart consecutively, line by line; if space is left, draw line horizontally though it and sign your name at end.</td>
</tr>
<tr>
<td><strong>If an order is questioned, record that clarification was sought</strong></td>
</tr>
<tr>
<td>Correct: do not record physician made error. instead, chart that &quot;Dr. Smith was called to clarify order for tidal volume. Include the date &amp; time of phone call, with whom you spoke, and the outcome</td>
</tr>
<tr>
<td><strong>Chart only for yourself</strong></td>
</tr>
<tr>
<td>Correct: Never chart for someone else.</td>
</tr>
</tbody>
</table>
Avoid using generalized, empty phrases such as "Status unchanged" or "had good day"

Rationale: This type of documentation is subjective and does not reflect patient assessment.

Correct: Use complete, concise descriptions of care so documentation is objective and factual.

Begin each entry with date and time and end with your signature and title

Rationale: This guideline ensures that correct sequence of events is recorded; signature documents who is accountable for care delivered.

Correct: Do not wait until end of shift to record important changes that occurred several hours earlier; be sure to sign each entry (e.g. Bob Smith, RRT)

For Computer documentation keep your password to yourself

Rationale: This maintains security and confidentiality

Correct: Once logged into computer, do not leave computer screen unattended. Log out when you leave the computer and make sure that screen is not accessible for public viewing.

Legislation

Health information in Alberta is regulated by the Health Information Act and the Freedom of Information and Protection of Privacy Act which protects patient/client privacy as well as matters related to confidentiality. The purposes of the Act are listed below and is increasingly important particularly as new social media platforms emerge and become mainstream in society. The legislature clearly indicates how important it considers health information is through approving the sixth purpose in the list which includes strong and effective remedies for any contraventions of the Act.

Purposes of Health Information Act

1. To establish strong and effective mechanisms to respect the privacy of individual’s health information and to protect the confidentiality of that information;
2. To enable health information to be shared and accessed and where appropriate to provide health services and to manage the health system;
3. To prescribe rules for the collection, use and disclosure of health information which are to be carried out in the most limited manner and with the highest degree of anonymity that is possible in the circumstances;
4. To provide individuals with a right of access to health information about themselves subject to specific and limited sections as set out in the Act;
5. To provide individuals with a right to request correction or amendment to health information about themselves;
6. To establish strong and effective remedies for contraventions of the Act and;
7. To provide independent reviews of decisions made by custodians under the Act and resolutions of complaints made under the Act.

Section 60 of the Act protects the personal health information of individuals held by custodians. Section 60(1)(c)(i) of the Act states:

“A custodian must take reasonable steps in accordance with the regulations to maintain administrative, technical and physical safeguards that will protect against any reasonably anticipated... Threat or hazard to the security or integrity of the health information or of loss of the health information.

Additionally, Section 38 of the Freedom of Information and Protection of Privacy Act states:

“The head of a public body must protect personal information by making reasonable security arrangements against such risks as unauthorized access, collection, use, disclosure or destruction.”

Standards of Practice Regarding Health Information

The following standards of practice of the profession related to documentation are contained in the table below. They are currently in force and every regulated member has annually executed during their initial application and every subsequent registration renewal a legal declaration stating that they have read, understand and agree to fully comply with these standards of practice as well as the code of ethics, the Respiratory Therapists Profession Regulation, Health Professions Act, Health Information Act and Freedom of Information and Protection of Privacy Act.

2.3 Ensures their professional practice complies with the Health Professions Act, Respiratory Therapists Profession Regulation, Bylaws, Standards of Practice, Code of Ethics, College Policies and procedures, and Employer Policies and Procedures.

2.4 Appropriately documents, on paper and/or electronic form, all information regarding initial assessments, patient response to therapeutic interventions and follow-up and discharge plans.

The RRT ensures that all documentation is legible, comprehensive, concise and pertinent. The RRT notes the date and time of each chart entry, and affixes their protected title and signature on all documentation. The RRT co-signs entries into the patient/client care record made by students.

2.5 Collaborates with others in the delivery of inter-disciplinary team health care services.

Contravention of these standards of practice may constitute unprofessional conduct as defined in section 1(pp) of the Health Professions Act. The standards of practice require every member to ensure that their documentation is legible, comprehensive, concise and pertinent to their respective findings rather than a summary of the collective findings already entered into the health record by other health care providers.

Readers will note the expectation that all regulated members are responsible for co-signing any entries made by a student when a regulated member is a preceptor. The spirit of this standard is to align with the purpose of the Health Information Act so that accurate information is contained in the patient’s/client’s health record.
Documentation Methods

The documentation method selected within a practice setting needs to reflect client care needs and the context of practice. Some employers may combine elements of different documentation methods and formats. If an employer decides to change its method or format of documentation and/or expectations, it is important that this be done within a context of appropriate planning and 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.

Three common documentation methods - FOCUS charting, SOAP and narrative documentation are described. Any of these methods may be used to document on an inclusion or exception basis.

FOCUS Charting

In focus charting, the assessment of patient status, the interventions carried out and the impact of the interventions on patient outcomes are organized under the headings of data, action and response.

Data: Subjective and/or objective information that supports the stated focus or describes the client status at the time of a significant event or intervention.

Action: Completed or planned nursing interventions based on the nurse’s assessment of the client’s status.

Response: Description of the impact of the interventions on client outcomes.

SOAP Charting

SOAP/SOAPIER charting is a problem-oriented approach to documentation whereby the respiratory therapist identifies and lists the problems; documentation then follows according to the identified problems. Documentation is generally organized per the following headings:

S = subjective data (e.g., how does the client feel?)
O = objective data (e.g., results of the physical exam, relevant vital signs)
A = assessment (e.g., what is the client’s status?)
P = plan (e.g., does the plan stay the same? is a change needed?)

Narrative Charting

Narrative charting is a method in which respiratory therapy interventions and the impact of these interventions on patient outcomes are recorded in chronological order covering a specific time frame. Data is recorded in the progress notes, often without an organizing framework. Narrative charting may stand alone or it may be complemented by other tools, such as flow sheets and checklists.
Charting by Exception

Charting by exception replaces the long-held belief of “if it was not charted, then it was not done” with a new premise, “all standards have been met with a normal or expected response unless documented otherwise.” Documentation by exception is only appropriate when assessment norms or standards of care are explicitly written and available. Documentation by exception is never acceptable for medication administration.

What Does It Mean to Co-sign/Countersign?

The definition of co-sign is “to agree or concur”. If you co-sign a student chart entry you are agreeing with the total entry. All co-signatures of student chart entries must be co-signed by the registered respiratory therapist witnessing the charted activity. If you are witnessing an activity, specify what you have witnessed. For example, if you co-sign that you witnessed the student performing an arterial blood gas you must have been present and the student has to be in your sight.

A countersignature is where an additional signature on a document that has already been signed. The countersignature is provided as confirmation or authentication.

The CARTA Standards of Practice require chart entries made by respiratory therapy students to be co-signed. See Standard 2.4 below.

2. Is Accountable for Their Professional Practice

2.4 Appropriately documents, on paper and/or electronic form, all information regarding initial assessments, patient response to therapeutic interventions and follow-up and discharge plans.

The RRT ensures that all documentation is legible, comprehensive, concise and pertinent. The RRT notes the date and time of each chart entry, and affixes their protected title or initials on all documentation. **The RRT co-signs entries into the patient/client care record made by students.**

Application of Technology

Technology supports patient documentation in many ways. When technology is used, the principles underlying documentation, access, storage, retrieval and transmittal of information remain the same as for a traditional, paper-based system.

Electronic Health Record

Documentation in electronic health records must be comprehensive, accurate, timely, and clearly identify who provided what care. Entries are made by the registered respiratory therapist providing the care and not by other staff. Entries made and stored in an electronic health record are considered a permanent part of the record and may not be deleted. If corrections are required to the entry after the entry has been stored, agency policies provide direction as to how this should occur. All employers using electronic documentation have policies to support its use, including policies for:
• correcting documentation errors or making “late entries”;
• preventing the deletion of information;
• identifying changes and updates to the record;
• protecting the confidentiality of client information;
• maintaining the security of the system (passwords, virus protection, encryption, firewalls);
• tracking unauthorized access to client information;
• processes for documenting in agencies using a mix of electronic and paper methods;
• backing-up client information; and
• means of documentation in the event of a system failure.

Guidelines for Using Electronic Health Records

1. Never reveal or allow anyone else access to your personal identification number or password as these are, in fact, electronic signatures;
2. Inform your immediate supervisor if there is suspicion that an assigned personal identification code is being used by someone else;
3. Change passwords at frequent and irregular intervals (as per employer policy);
4. Choose passwords that are not easily deciphered;
5. Log off when not using the system or when leaving the terminal;
6. Maintain confidentiality of all information;
7. Shred any discarded print information containing client identification;
8. Locate printers in secured areas away from public access;
9. Retrieve printed information immediately;
10. Protect client information displayed on monitors (e.g., use of screen saver, location of monitor, use of privacy screens);
11. Use only systems with secured access to record client information; and only access client information which is required to provide nursing care for that client; accessing client information for purposes other than providing nursing care is a breach of confidentiality.

Guidelines on Facsimile Transmission

Regulated members need to be mindful of the recommendations of the privacy commissioner’s office with respect to faxing a patient’s/client’s health information. Faxing patient/client information such as prescriptions for oxygen therapy to homecare service providers is a common example in our industry.

When the prescription information is faxed to a homecare service provider there should be a confirmation of receipt sent by the service provider rather than the sender relying on their own facsimile’s confirmation of sending a document. If a confirmation of receipt of the prescription is not received by the sender, then they should follow-up by communicating with the intended recipient service provider and confirm whether in fact the facsimile was received and that the transmission was not subject to significant optical character degradation and the communication is legible for the recipient to read.

1. Always confirm that the receiver has taken appropriate precautions to prevent anyone else from seeing the faxed documents;

5 Appendix 2 Guidelines on Facsimile Transmission
2. Before sending a fax, check that the receiver's number is correct, then verify in the machine's display window that you have keyed it in correctly;
3. If you must send personal information, always complete the fax cover sheet, clearly identifying both sender and intended receiver. The cover sheet should include a warning that the information is private and confidential and that you should be notified immediately if the information is received in error;
4. Call the recipient to verify that he or she received the complete transmission; or check the confirmation sheet to see that it went through to the correct number;
5. Any fax machine used to send or receive personal information should be kept in a location where unauthorized persons cannot see the documents. If there is no appropriate location, someone should be watchful of the machine while in operation;
6. Limit the chances that passers-by can see personal documents by sending the documents yourself;
7. Try to arrange a time to receive faxes containing personal information so you can be at the machine as they arrive;
8. Fax only the personal information which you would feel comfortable discussing over the telephone;
9. If your fax machine is equipped, use the feature requiring the receiver to enter a password before the machine will print the fax. This ensures that only the intended receiver can retrieve the document. Similarly, ask the sender to make sure you must supply a password to retrieve the document;
10. Security precautions should be taken for faxes received after normal office hours;
11. If you are sending personal information by a fax modem (a fax device contained in a computer), confirm that other users of the computer system cannot get access to the fax without a password. Likewise, if you are expecting information by fax modem, ensure that other users of your system cannot access the information without a password;
12. If possible, use encryption technology or other technology to secure fax transmissions;
13. Be aware that your fax number can be re-assigned once you have given up the number. It is possible to “purchase” the rights to that line so that the number is never re-assigned.

**Telehealth**

The use of information and communication technologies in clinical and professional practice has grown considerably, improving access to services and care, facilitating the transfer of information amongst care providers and in certain circumstances reducing costs associated with care. Professional practice has been affected by information and communication technologies use, which means that certain adaptations must be made to ensure secure and quality delivery of services/care.

Telehealth utilization is increasing and includes, teleconsulting, tele-expertise, tele-monitoring, tele-assistance, and tele-imaging as well as for educational training and supervisory activities. The notion of tele-practice includes telehealth for the purposes of this practice guideline it also includes the use of mobile telephones and the internet. Activities associated with tele-practice include public information by means of information and communication technologies, remote delivery of professional services to patients, management and sharing of patient confidential information and digital records.

Telehealth introduces a whole new opportunity for utilization as well as potential liabilities associated with their use. Telehealth services to patients also require documentation and may get complicated when you are providing services to another regulated jurisdiction other than within Alberta. Typically,
the documentation standards in the receiving jurisdiction would be applicable. If the jurisdiction is not regulated it is reasonable to assume the Alberta standards would be applicable in the absence of any other standard available.

Factors to consider when providing telehealth services would include the following general principles:

- Free and informed patient consent must be obtained for the service as well as the tele-practice;
- Patient confidentiality is ensured when delivering services at a distance;
- Emergency protocols should be in place to respond to any technical or clinical emergency to ensure the physical and psychological security of persons requiring care via this method;
- Reliability of any measuring instruments or mobile applications used for a distance service. Results and their interpretations must be valid and identical to those that may be obtained face to face;
- Where applicable the regulated member must make sure that the application of software they are using in interoperable with the systems in place, availability of any data, confidentiality of any data and integrity of any of the data.
Frequently Asked Questions

1. What is considered “timely” documentation?

The timeliness of documentation will be dependent upon the client. When client acuity, complexity and variability are high, documentation will be more frequent than when clients are less acute, less complex and/or less variable.

2. Who owns the health record?

The agency in which the client’s health record is compiled is the legal owner of the record as a piece of physical or electronic property. The information in the record, however, belongs to the client. Clients have a right of access to their records and to protection of their privacy with respect to the access, storage, retrieval and transmittal of the records. The rights of clients and obligations of public agencies are outlined in the Freedom of Information and Privacy Act and are often summarized in agency policies.

3. How does the Freedom of Information and Protection of Privacy Act (FOIPPA) affect documentation?

The FOIPPA provides the legislative framework for information and privacy rights. This act applies to all public bodies, including hospitals, health authority boards, and similar organizations. The legislation gives the public a right of access to records held by one of these public bodies. Individuals have a right of access to personal information about themselves (including their health records) and a right to request correction of such information. The act also prevents the unauthorized collection, use or disclosure of personal information by a public body.

4. Is the information in the client’s health record confidential?

Yes. Information in the health record is considered confidential. Patient consent for disclosure of this information to staff for purposes related to care and treatment is implied upon admission, unless there is a specific exception established by law or agency policy. Client consent is required if the contents of the health record are to be used for research or if any client information is to be transmitted outside the agency.

Documentation must be produced according to agency policy when:

- patients request access to their personal records;
- CARTA, under the Health Professions Act and Regulation needs to inspect or investigate records;
- a subpoena is provided (e.g., negligence suit); or
- a statutory mandate requires the release of the information (e.g., reporting communicable diseases or child abuse).

5. Under which circumstances are verbal orders appropriate?

On-site verbal orders also have the potential for error and are avoided unless in an emergency, such as a cardiac arrest. Respiratory Therapists need to be aware of the employer’s policy about accepting and documenting on-site verbal orders.
Appendix 1: Do Not Use Dangerous Abbreviations, Symbols, and Dose Designations

# Do Not Use

## Dangerous Abbreviations, Symbols and Dose Designations

The abbreviations, symbols, and dose designations found in this table have been reported as being frequently misinterpreted and involved in harmful medication errors. They should NEVER be used when communicating medication information.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Intended Meaning</th>
<th>Problem</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>unit</td>
<td>Mistaken for “0” (zero), “4” (four), or cc.</td>
<td>Use “unit”.</td>
</tr>
<tr>
<td>IU</td>
<td>international unit</td>
<td>Mistaken for “IV” (intravenous) or “10” (ten).</td>
<td>Use “unit”.</td>
</tr>
<tr>
<td>Abbreviations for drug names</td>
<td></td>
<td>Misinterpreted because of similar abbreviations for multiple drugs; e.g., MS, MSO	extsubscript{4} (morphine sulphate), MgSO	extsubscript{4} (magnesium sulphate) may be confused for one another.</td>
<td>Do not abbreviate drug names.</td>
</tr>
<tr>
<td>QD QOD</td>
<td>Every day, Every other day</td>
<td>OD and QOD have been mistaken for each other, or as ‘qid’. The Q has also been misinterpreted as “2” (two).</td>
<td>Use “daily” and “every other day”.</td>
</tr>
<tr>
<td>OD</td>
<td>Every day</td>
<td>Mistaken for “right eye” (OD = oculus dexter).</td>
<td>Use “daily”.</td>
</tr>
<tr>
<td>OS, OD, OU</td>
<td>Left eye, right eye, both eyes</td>
<td>May be confused with one another.</td>
<td>Use “left eye”, “right eye” or “both eyes”.</td>
</tr>
<tr>
<td>D/C</td>
<td>Discharge</td>
<td>Interpreted as “discontinue whatever medications follow” (typically discharge medications).</td>
<td>Use “discharge”.</td>
</tr>
<tr>
<td>cc</td>
<td>cubic centimetre</td>
<td>Mistaken for “u” (units).</td>
<td>Use “mL” or “millilitre”.</td>
</tr>
<tr>
<td>μg</td>
<td>microgram</td>
<td>Mistaken for “mg” (milligram) resulting in one thousand-fold overdose.</td>
<td>Use “mcg”.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Intended Meaning</th>
<th>Potential Problem</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>@</td>
<td>at</td>
<td>Mistaken for “2” (two) or “5” (five).</td>
<td>Use “at”.</td>
</tr>
<tr>
<td>&gt;</td>
<td>Greater than</td>
<td>Mistaken for “7” (seven) or the letter “L”. Confused with each other.</td>
<td>Use “greater than”/“more than” or “less than”/“lower than”.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dose Designation</th>
<th>Intended Meaning</th>
<th>Potential Problem</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trailing zero</td>
<td>.0 mg</td>
<td>Decimal point is overlooked resulting in 10-fold dose error.</td>
<td>Never use a zero by itself after a decimal point. Use “.0 mg”.</td>
</tr>
<tr>
<td>Lack of leading zero</td>
<td>.0 mg</td>
<td>Decimal point is overlooked resulting in 10-fold dose error.</td>
<td>Always use a zero before a decimal point. Use “0.0 mg”.</td>
</tr>
</tbody>
</table>

Adapted from ISMP’s List of Error-Prone Abbreviations, Symbols, and Dose Designations 2006

Report actual and potential medication errors to ISMP Canada via the web at https://www.ismp-canada.org/err_report.htm or by calling 1-866-54-ISMP. ISMP Canada guarantees confidentiality of information received and respects the reporter’s wishes as to the level of detail included in publications.

Permission is granted to reproduce material for internal communications with proper attribution. Download from: www.ismp-canada.org/dangerousabbreviations.htm
Appendix 2: Guidelines on Facsimile Transmission

Guidelines on Facsimile Transmission

The purpose of this document is to set out guidelines for public bodies and custodians to follow when developing systems and procedures to maintain the confidentiality and integrity of personal information received and transmitted by fax. Private sector organizations may also find these guidelines helpful.

One of the purposes of the Health Information Act is to protect the personal health information of individuals held by custodians. Section 60(1)(c)(i) states:

60 A custodian must take reasonable steps in accordance with the regulations to maintain administrative, technical and physical safeguards that will...
   (c) protect against any reasonably anticipated...
   (f) threat or hazard to the security or integrity of the
   health information or of loss of the health information.

Additionally, section 38 of the Freedom of Information and Protection of Privacy Act states:

38 The head of a public body must protect personal information by making reasonable security arrangements against such risks as unauthorized access, collection, use, disclosure or destruction.

How can I reduce the risk of accidentally disclosing personal information when using a fax machine?

- Always confirm that the receiver has taken appropriate precautions to prevent anyone else from seeing the faxed documents;
- Before sending a fax, check that the receiver's number is correct, then verify in the machine's display window that you have keyed it in correctly;
- If you must send personal information, always complete the fax cover sheet, clearly identifying both sender and intended receiver. The cover sheet should include a warning that the information is private and confidential and that you should be notified immediately if the information is received in error;

Office of the Information and Privacy Commissioner Guidelines on Facsimile Transmission
Version 2 – revised October 2002
Call the recipient to verify that he or she received the complete transmission; or check the confirmation sheet to see that it went through to the correct number;

- Any fax machine used to send or receive personal information should be kept in a location where unauthorized persons cannot see the documents. If there is no appropriate location, someone should be watchful of the machine while in operation;

- Consider making one individual responsible for the fax machine. Otherwise, limit the chances that passers-by can see personal documents by sending the documents yourself;

- Try to arrange a time to receive faxes containing personal information so you can be at the machine as they arrive;

- Fax only the personal information which you would feel comfortable discussing over the telephone;

- If your fax machine is equipped, use the feature requiring the receiver to enter a password before the machine will print the fax. This ensures that only the intended receiver can retrieve the document. Similarly, ask the sender to make sure you must supply a password to retrieve the document;

- Security precautions should be taken for faxes received after normal office hours;

- If you are sending personal information by a fax modem (a fax device contained in a computer), confirm that other users of the computer system cannot get access to the fax without a password. Likewise, if you are expecting information by fax modem, ensure that other users of your system cannot access the information without a password;

- If possible, use encryption technology or other technology to secure fax transmissions;

- Be aware that your fax number can be re-assigned once you have given up the number. It is possible to “purchase” the rights to that line so that the number is never re-assigned.

---

This Guideline is based upon and imports many of the practices and guidelines from a number of organizations including the Privacy Commissioner of Canada, the Office of the Information and Privacy Commissioner of British Columbia, the Office of the Information and Privacy Commissioner of Ontario, the College of Physicians and Surgeons of Alberta, and the Canadian Health Record Association. Their contributions are gratefully acknowledged.

A custodian is defined as an entity or registered health professional (e.g., physician) in the publicly funded health system who receives and uses health information. Custodians are responsible for ensuring that the health information is collected, used, disclosed and protected appropriately.

Office of the Information and Privacy Commissioner Guidelines on Facsimile Transmission
Version 2 – revised October 2002
Appendix 3: CARTA Standards of Practice

Standards of Practice

OBLIGATIONS OF A REGULATED HEALTH PROFESSION

CARTA’S Standards of Practice are derived from the following obligations of a regulated health profession, to:

1. Provide professional, safe and quality services to the public.
2. Be accountable for their professional practice.
3. Adhere to the Code of Ethics.
4. Possess a specialist body of knowledge.
5. Demonstrate competent application of professional knowledge.
6. Abide by continuing competence requirements.

1. Provide Professional, Safe and Quality Services to the Public

The RRT uses a patient-focused approach to provide safe, quality care to patients, inherent with the privilege of self governance. The RRT:

1.1 Uses clinical judgement, including determining any contraindications prior to any intervention, to assess, treat, manage and evaluate the patient’s health care needs, on an ongoing basis.

1.2 Consults when necessary with other regulated health care practitioners, and (where appropriate) with regulated health care workers, prior to initiating treatment.

1.3 Evaluates the patient’s progress toward the achievement of anticipated clinical outcomes, and maintains, revises or discontinues treatment, in consultation with the patient and other regulated health care professionals.

1.4 Communicates effectively with patients, family and the health care team regarding the patient’s respiratory and health status, and profess with respect to the treatment plan.

1.5 Protects and maintains the patients’ rights to privacy, safety, dignity and confidentiality.

1.6 Manages available resources effectively and efficiently in meeting patient’s needs.

1.7 Uses critical thinking skills and competencies to analyze, synthesize and apply information to improve the quality, efficiency and effectiveness of patient care.

1.8 Recognizes their competency limitations, and when necessary seeks assistance, guidance, and expertise from others.

1.9 May refuse to provide professional health services, if in the RRT’s professional opinion, the ordered service or procedure may be detrimental to the patient’s health status, or may otherwise be inappropriate. In these circumstances, the RRT will convey their professional opinion to the practitioner who ordered the service.
Performance Indicators

In clinical, educational, management and research practice settings, the RRT:

- forms relationships with patients and other health professionals based on compassion, mutual respect, trust, and open and honest communication.
- recognizes the value of other health professions and collaborates as appropriate in patient-centered care.
- evaluates the risks and benefits of therapeutic interventions.
- recognizes the limitations of their competencies, and seeks assistance, guidance and intervention from others as appropriate.
- understands the importance of creating a learning environment for students and treats preceptorship of students as a professional responsibility.
- treats students with dignity and respect and continually provides clear, honest and objective feedback.
- reports on unsafe practice or unprofessional conduct to the appropriate authority.
- assists colleagues, students and others to learn about respiratory therapy practice and health care services.
- renders assistance to any person, within the RRT’s level of competence, where an urgent need for health care exists.
- does not falsely or frivolously impugn the reputation of another member or colleague.
- demonstrates a thorough understanding of multi-disciplinary versus interdisciplinary teams in the provision of patient care services.
- provides leadership by facilitating and advocating for patient care needs.
- allocates available resources to promote effective and efficient care.
- evaluates outcomes in relation to respiratory care.
- Obtains an appropriate consent for care, treatment and participation in research.

2. Is Accountable for Their Professional Practice

The RRT is accountable to the College and the public to ensure their practice meets legislative and professional requirements. The RRT takes accountability and intervenes – rather than watching, waiting, documenting or commenting. The RRT:

2.1 Ensures they are in good standing the CARTA, and where possible and time permits, contributes to the College’s self-governance and related activities.

2.2 Assumes accountability and responsibility for their professional competencies, in part through participating in the Continuing Competency Program. This includes developing and maintaining the RRT’s competencies through conducting annual competency assessments, determining their strengths and learning needs, and undertaking measures to meet these learning needs.

2.3 Ensures their professional practice complies with the HPA, Respiratory Therapists Profession Regulation, Bylaws, Standards of Practice, Code of Ethics, College Policies and procedures, and Employer Policies and Procedures.
2.4 Appropriately documents, on paper and/or electronic form, all information regarding initial assessments, patient response to therapeutic interventions and follow-up and discharge plans.

The RRT ensures that all documentation is legible, comprehensive, concise and pertinent. The RRT notes the date and time of each chart entry, and affixes their protected title or initials on all documentation. The RRT co-signs entries into the patient/client care record made by students.

2.5 Collaborates with others in the delivery of inter-disciplinary team health care services.

**Performance Indicators**

In clinical, educational, management and research practice settings, the RRT:

- demonstrates competency within the specialist body of knowledge;
- maintains privacy and ensures confidentiality relating to health information;
- practices within the skills and abilities for the level of knowledge;
- is able to function independently and forms interdependent relationships with appropriate members of the health care team;
- documents assessment, diagnostic and therapeutic interventions, and forms a care plan;
- reports instances of unsafe professional practice, misconduct or patient abuse by a peer or other health care provider to the appropriate authority;
- develops curricula that reflect the competencies identified in the national competency profile;
- shares their knowledge and expertise with students and colleagues;
- identifies competency-based objectives;
- demonstrates mutually respectful and trusting relationships with students and preceptors;
- ensures job functions are within the identified practice statement (“scope of practice”/”practice statements”);
- provides safe, respectful and patient-centered practice environments;
- requires that all practitioners have current practice permits and appropriately use the protected titles;
- ensures that protocols and policies are supported by evidence informed practices;
- participates in research projects only after appropriate research and ethics approval has been granted;
- reports instances of inconsistent or poor outcomes to the appropriate authority;
- facilities implementation of research findings to evidence-based practice;

3. **Adheres to the Code of Ethics**

The RRT practices within the ethical guidelines of the profession. The RRT:

3.1 Demonstrates, through example and behaviour, adherence to CARTA’s Code of Ethics.

3.2 Supports ethical behaviour in practice, education and research.
3.3 Reports unsafe practice and unprofessional conduct by CARTA’s regulated members to CARTA’s “Complaints Director”, particularly in circumstances that may jeopardize patient care and/or bring the professions’ reputation into disrepute.

3.4 Protects the patient’s right to autonomy, respect, confidentiality and access to information, in accordance with applicable federal and provincial legislation.

Performance Indicators

In clinical, educational, management and research practice settings, the RRT:

- upholds the values contained in the Standards of Practice and Code of Ethics.
- develops processes for ethical decision making.
- bases their workplace ethics to ensure compliance with CARTA’s expectations.
- participates in projects only where formal research and ethics approval has been granted. This includes drug studies, epidemiological studies, first application in humans, multi-center trials, pilot projects, qualitative studies, and technology assessment.
- Additional items that may be considered are privacy and confidentiality, risks and benefits, patient recruitment procedures, informed consent, conflict of interest, and financial remuneration.

4. Possesses a Specialist Body of Knowledge

The RRT is knowledgeable about the biological, physiological, medical, social and psychological sciences inherent in respiratory therapy health services. The RRT:

4.1 Develops and maintains their knowledge of the biological, physical, social and psychological arts and sciences, consistent with the national competency profile.

4.2 Possesses knowledge relevant to the role and responsibilities of area of practice.

4.3 Assumes responsibility for their personal and professional development.

4.4 Acts as teacher, advisor and mentor to students, peers and members of the health team and patients.

4.5 Promotes ongoing development and growth of knowledge of the profession by engaging in education and research.

Performance Indicators

In clinical, educational, management and research practice settings, the RRT:

- understands and analyzes the concepts of normal functioning, and acute and chronic dysfunction due to cardio-respiratory status.
- demonstrates knowledge of the principles, practices and associated risks of procedures and interventions.
- displays expertise relating to the application of technology and equipment.
- is able to perform, analyze and interpret cardio-respiratory function tests and assessments.
- interprets variations in normal and abnormal results.
• formulates care plans and recommendations based on interpretations of results, assessments and available technology.
• promotes respiratory health and utilizes disease prevention and management strategies.
• is aware of major social and disease trends affecting respiratory health.
• designs competency-based objectives to meet the unique and specialized body of knowledge identified under clinical practice indicators.
• utilizes an evaluation process to promote learning of the unique and specialized body of knowledge.
• supports and assists educational institutions to participate in accreditation processes, in part to continually improve learning techniques associated with the body of knowledge.
• promotes the growth of evidence informed practices associated with the body of knowledge.
• makes use of performance management that reflect the unique and specialized knowledge base.
• develops action plans to address competency deficiencies associated with clinical practice.
• understands the underlying principles of research, as they apply to the unique and specialized knowledge required for the practice setting.
• is able to interpret the level of research variability and dependability associated with specialized knowledge.

5. Demonstrates the Competent Application of Professional Knowledge

The RRT competently applies the body of knowledge to the assessment, treatment and management of patients. The RRT:

5.1 Performs a comprehensive assessment of patient’s status to formulate goals and objectives to meet patient health care needs.

5.2 Develops action and treatment plans based upon patients’ conditions.

5.3 When possible, continually and formally evaluates their provision of health care services through peer reviews and debriefings, management reviews and other quality assurance mechanisms. The intent of continuous evaluation is to improve patient safety and quality of care.

The concept of evaluation is consistent with performance management, which implies benchmarking, research, evaluation and a “systems level” of thinking.

5.4 Applies knowledge gained from evidence informed practices, experience, clinical judgement and research findings.

Performance Indicators

In clinical, educational, management and research practice settings, the RRT:

• performs assessments, evaluates test results and performs interventions in consultation with patients and other members of the health care team. This includes mechanically augmented ventilation, medication administration, medical gas administration,
cardiopulmonary resuscitation and airway care. A more comprehensive listing of interventions is contained in the national competency profile.

- evaluates, documents and modifies interventions based on patient outcomes.
- performs cardiopulmonary diagnostics including the broad headings of pulmonary function testing, cardiac testing, metabolic studies, vascular testing and sleep diagnostics. A more comprehensive list of diagnostic testing is contained in the national competency profile.
- promotes safety and manages risk by using routine precautions for infection control, using protective devices, additional precautions for infection control, risk management strategies and reduction and elimination of biohazards and environmental hazards.
- promotes respiratory health and independence through pulmonary rehabilitation strategies, home environment analysis, education, coaching and counseling.
- develops curricula to achieve competence for students as noted under the clinical practice indicators.
- utilizes an evaluation process to promote competent application of knowledge, skills, attitude, judgment and experience.
- supports an accreditation process to continuously improve the competent application of knowledge, skills and attitudes.
- performs a cost-benefit analysis of therapeutic modalities.
- measures workloads and analyzes the types of interventions, activities, geography, functions and productivity.
- assesses patient satisfaction.
- conducts safety audits.
- performs risk management strategies.
- evaluates literature pertaining to clinical practice areas and incorporates this into evidence-based practice.
- utilizes available meta-analysis for determining evidence associated with clinical interventions and application of technology.
- utilizes their experience in consultation with patients to determine the care plan and associated outcomes.
- participates in research to advance evidence-based practice.

6. Abides by Continuing Competence Requirements

The RRT demonstrates commitment to life long learning and “currency in practice”, inherent in the privilege of being a self-governing profession. The RRT:

6.1 Strives for professional excellence by participating in and promoting self-assessment and feedback from others to review and implement changes in practice.

6.2 Invests the time, effort and resources needed to maintain and/or improve the competencies required in the area of practice.

6.3 Uses an organized and focused approach in assessing their level of competence based on evidence informed practices, determining the competency requirements identifying their learning needs, and then developing a strategy to address those learning requirements.
6.4 Develops and maintains their competence through conducting annual competency assessments, determining their strengths and learning needs, and undertaking measures to meet their learning needs, based on evidence informed practices.
Appendix 4: CARTA Code of Ethics

As registered respiratory therapists (RRT), we individually and collectively strive to maintain the highest ethical, professional and moral standards. RRTs are obliged to provide competent, safe and respectful care, which respects the integrity of the clinician/patient relationship. We must deal in a dignified manner with colleagues, patients and members of the public, and demonstrate accountability for our actions.

The following principles outline the expectations:

1. Each RRT shall do what is reasonable and appropriate under the circumstances to gain the respect and confidence of other health care personnel, as well as respecting the human dignity of their colleagues and associates.
2. Each RRT must execute their professional responsibilities in a competent, efficient and effective manner. The patient’s well-being and safety shall always be of paramount concern.
3. Each RRT shall limit their performance of health services to their level of competence (as defined in the Health Professions Act), irrespective of their authorization. This limitation is guided by the RRT’s education, experience and “currency in practice”.
4. Each RRT shall keep in confidence all privileged patient information. Each RRT shall collect and disseminate patient information in accordance with federal and provincial legislation.
5. Each RRT shall guard against conflicts of professional interest. A “conflict of professional interest” is any situation where an RRT has competing motivations or responsibilities, whether real or perceived, where the resulting action may be to the detriment of the respiratory therapy profession, other members of the profession, or their responsibility as an RRT.

The RRT should proactively consult with the Registrar in these circumstances, ideally to prevent a real or perceived conflict of interest.

6. Each RRT shall ensure that their patients provide informed consent, by reviewing the risks and benefits, as well as the specific health services and procedures. Informed consent implies (1) appropriate disclosure of information, (ii) patient understanding of the information, and (iii) the patient expressing a voluntary choice to proceed with the recommended assessment and/or treatment.
7. Each RRT shall assume responsibility for referring instances of actual or perceived “unprofessional conduct” (as defined in the Health Professions Act) to the applicable College’s (including CARTA) Complaints Director.
Bibliography

Resources for Regulated Members

1) Guidelines for the Protection of Health Information (2013) Canada’s Health Informatics Association;
2) Health Information Act;
3) Health Professions Act;
4) Respiratory Therapists Profession Regulation;
5) Standards of Practice;
6) Code of Ethics;
7) Telepractice and Digital Records Management in the Health and Human Relation Sectors;
8) Freedom Of Information and Protection Of Privacy Act
9) Employer(s) Policies