Clinical Process Instruction Manual

Documentation of Clinical Notes Process Instruction

Policy:

A donor record is the systematic documentation of a single donor or potential donor's case, including but not limited to, flow sheets, forms, donor management system (DMS) data fields, attachments, and the clinical notes section. This process instruction will focus on the clinical notes section of the donor record. Clinical notes is a narrative section in which the Trillium Gift of Life Network (TGLN) coordinators document all pertinent case information that is not captured in other areas of the donor record. This section has two key functions: communicate relevant case information between case team members, and support compliance with policies, regulations, professional standards and legislation.

Clinical notes document all relevant data, actions, and outcomes through the continuum of a donation case from receipt of referral through to closing of a case. Specific documentation requirements and case milestones may differ based on the clinical role. The clinical notes should reflect role specific guidelines as outlined in the relevant clinical process instructions.

For the purpose of this document, a TGLN coordinator is defined as a Referral Triage Coordinator (RTC), Specialist - Organ and Tissue Donation (S-OTD), Clinical Responder (CR), Clinical Services Coordinator (CSC), Tissue Coordinator (TC), Surgical Recovery Coordinator (SRC), Multi-Tissue Recovery Coordinator (MTRC) and/or a Tissue Recovery Coordinator (TRC).

Process:

General

1. TGLN coordinators remain accountable to individual specific licensing self-regulating body or college and standards for documentation, where applicable.

2. The goal of clinical notes documentation is to have an accurate, factual and chronological record of all case activities, decisions, and outcomes.

3. Documentation should not be duplicated, but must include all data, actions, and outcomes as applicable. Documentation may occur across different sections of the chart. Clinical notes may reference other areas of the donor record.

4. The clinical notes section of the *Eye Recovery Form* is a part of the clinical notes section.

5. Clinical notes documentation will not contain first person pronouns.

6. Donor records may be requested or accessed by individuals or third parties under Freedom of Information requests (i.e. donor family's, executors, legal representatives), thereby, giving access to the clinical notes as per TGLN Privacy Policy.

7. By signing an entry, either manually or electronically, a TGLN coordinator is attesting that information is entered to the best of their knowledge, skill, and judgment.

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Errors and Amendments

8. A clinical note may be necessary where changes are made to documentation. This may involve new information, changes in clinical path, or a quality amendment request.

9. Errors made in documentation in DMS are to be noted by using the format "incorrect entry" or "wrong chart." Delete text if applicable, deleted notes can be viewed in the audit trail.

10. Errors made in documentation on hardcopy forms must be completed as per *Making Error and Information Corrections – Hardcopy Forms Process Instruction, CPI-9-806.*

Factual

11. All relevant objective and subjective data, actions, and outcomes are to be documented. This does not include personal opinions, feelings, judgments, and information not relevant to the documented event. Refer to Appendix 1: Data- Action- Response (DAR) Guidelines.

12. Where applicable, subjective data or direct words from stakeholder quotes are to be documented

13. The use of "copy and paste" of pertinent email and text communication beyond language used to describe reason for decline of an organ is only permitted with the explicit permission from the writer of the email or text for TGLN internal staff.

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Complete

14. All relevant information is to be captured in the donor record.

15. Where applicable, all components of an entry are to be documented. Different components may be documented in different areas of the chart, i.e. flow sheets, attachments, and are not limited to clinical notes.
    - data: objective and subjective
    - actions taken or planned
    - responses (or outcomes)

See Appendix 1: Data- Action- Response (DAR) Guidelines

Timing

16. Documentation should occur during, or soon as possible after the event.

17. Late entries in documentation should be written using the format “late entry (date/time)”

18. Where applicable, reasons for delays in a donor case should be documented.

Communication with internal/external stakeholders

19. For all next-of-kin (NOK) discussions, clinical notes will specify, as applicable:
    - names and relationship of person’s contacted
    - all attempts to contact family including voice mails left by TGLN staff or unanswered calls
    - description of information provided including, but not limited to: case timing, funeral arrangements, process, and special requests

20. Documentation of all pertinent case communication with external and internal stakeholders may include but is not limited to:
    - name, status and affiliation or relationship
    - mode of communication
    - details of communication, including but not limited to: data, actions, responses, recommendations provided, case updates, key decisions made, other pertinent information received or conveyed.

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21. In certain circumstances, a designated recorder may be assigned:
    - 21.1. When TGLN coordinators are communicating with each other, all coordinators will document the conversation, unless a designate recorder is assigned.
    - 21.2. A TGLN coordinator acting as a designate recorder may include details including, but not limited to, name, title, and circumstance for documentation.

Records:

- *No records.*

References:

- *Team Huddle Planning, CPI-9-201*
- *Donor Assessment, CPI-9-208*
- *Making Error and Information Corrections – Hardcopy Forms, CPI-9-806*
- *College of Nurses of Ontario. (2008). Practice Standard; Revised 2008. http://www.cno.org/globalassets/docs/prac/41001_documentation.pdf*
- *College of Physiotherapists of Ontario. (2017). Record Keeping; Guide to the Standard for Professional Practice. https://www.collegept.org/rules-and-resources/record-keeping*
- *American association of Tissue Banks. (2016). Standards for Tissue Banking; 14th edition; Accreditation Policies and Guidance Documents AATB - Standards for Tissue Banking 14th Edition.pdf (giftoflife.on.ca)*
- *TGLN Privacy Policy*

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Appendix 1: Data- Action- Response (DAR) Guidelines

***D*ata:** All objective (and acceptable subjective) information that supports or describes the event.

- Summary of event/interaction/problem-Include all relevant facts of the case, be specific
- Date and time
- Name, status, and affiliation of persons involved

Objective data: can be seen, heard, measured, or referenced back to reliable sources
Subjective data: what someone says, interprets, or feels (Should be used as a quote with supporting objective data if applicable)

***A*ction**: Completed or planned actions based on the data provided.

- Past, Present, or future actions taken for case needs based on data
- Description of pertinent details
- Changes required to current plan
- The resulting plans made

***R*esponse:** Description of the response/outcome to the action and progress of case if applicable

- Response or the outcome of action/event
- Further actions that are needed (i.e. follow-up).
- The resulting plan for future case activities.

- ***DAR notes do not need to always have all three components. Some notes will just contain one or two of the three parts.***
- ***All components may reference flow sheets or data fields in the donor record***